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Budget and Legislative Program

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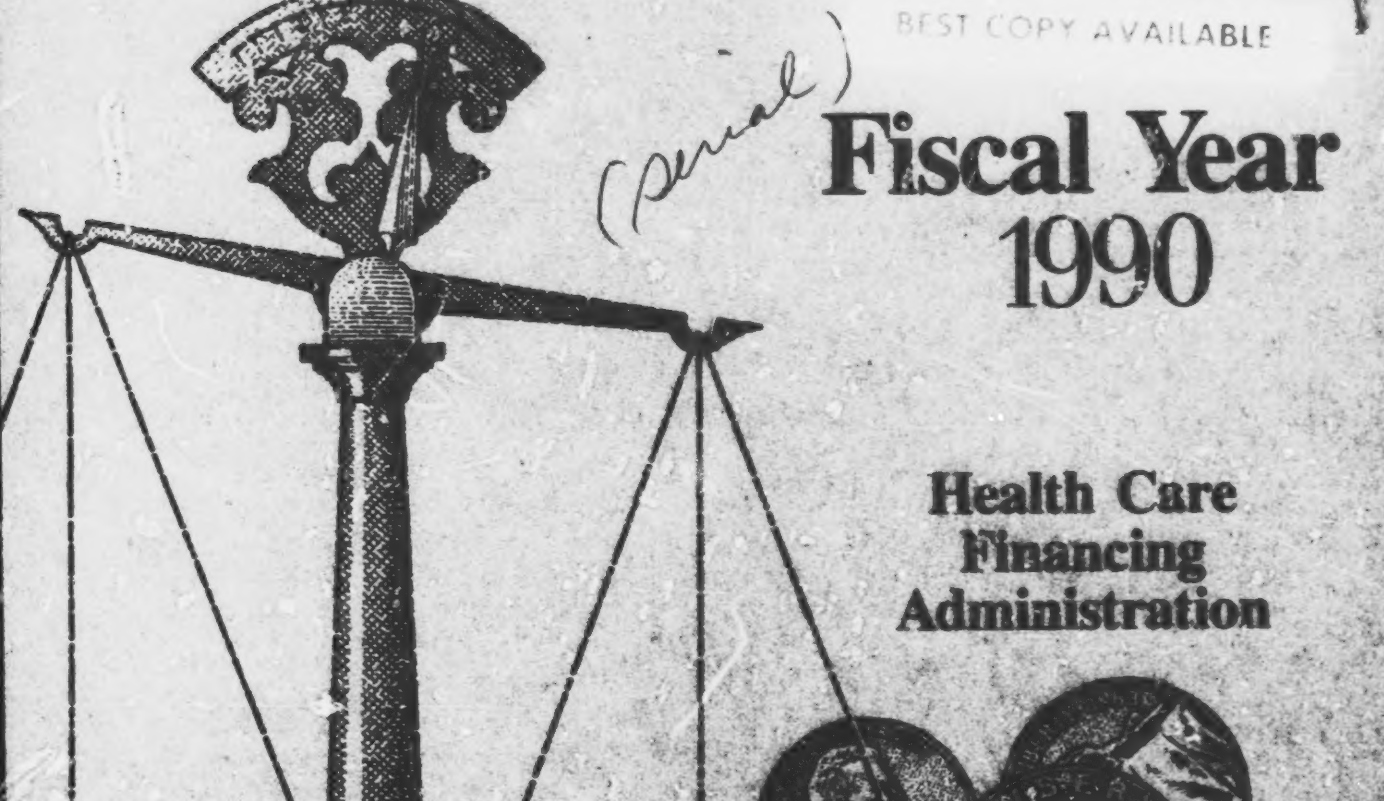
Fiscal Year 1990



Health Care Financing Administration

ORIGINAL

U.S. Department
Health and Human Servic

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

Date JUN 10 1988

From William L. Roper, M.D. WLR
Administrator

Subject FY 1990 Budget Request

To S. Anthony McCann
Assistant Secretary for Management
and Budget

As head of the Health Care Financing Administration (HCFA), I am pleased to submit to you my agency's budget request for Fiscal Year 1990. The materials that follow specify and explain our requested funding levels for Medicare and Medicaid benefits, administrative expenses of the contractors and of HCFA, and expected costs of other program management activities. As instructed, we have forwarded details of our legislative and regulatory program separately to the Assistant Secretary for Planning and Evaluation, although the major cost/savings impact of these proposals is reflected in our budget submission.

HCFA's budget request attempts to balance the Government-wide effort to achieve fiscal restraint with the need to carry out a wide range of new activities, most of which are required by Congress and many of which are of high priority to the Administration. While HCFA has been looked to each year for a disproportionate share of budget savings to meet a Departmental target, we have also been the object of intense legislative interest resulting in new tasks and increased workloads. In addition, we have an ambitious agenda of projects and initiatives of our own, some of which are Secretarial initiatives and some of which originated in HCFA.

Overall, we have met the savings target you provided, despite our request for sizable increases in several of the program management accounts. Expected savings from new legislative proposals of $1.3 billion will not only meet the savings target of $1.0 billion (in addition to savings from FY 1989 proposals with "slipped" effective dates), but will also offset the increases contemplated in spending for research, contractors, state certification, HCFA administrative costs, etc.

Impact of Recent Legislation

Since we submitted our FY 1989 budget request one year ago, the Congress has enacted yet another wide-ranging set of Medicare and Medicaid revisions as part of the Omnibus Budget Reconciliation Act of 1987. In addition, final passage of historic legislation extending Medicare protection to elderly and disabled persons who experience catastrophic medical expenses has just taken place and the bill is expected to be signed into law very soon. These legislative accomplishments will impose heavy new workloads on the Health Care Financing Administration and have been reflected to the extent possible in our budget request.

More precisely, OBRA 1987 implementation and execution activities have been incorporated in our baseline or current law estimates. Expected workloads and costs associated with particular OBRA provisions have been highlighted where appropriate. Predicting the impact of catastrophic health insurance implementation on HCFA's resource needs has been much more complex. Because key provisions of the bill have been in flux right up until the due date for this Departmental budget submission, our ability to update and refine earlier estimates of benefit and administrative costs has been very limited. As more information and analysis becomes available to us over the coming weeks, we will supply supplementary materials on the budgetary impact of catastrophic health insurance implementation in FY 1990 and beyond. By the time the Department submits its FY 1990 budget request to the Office of Management and Budget in September, we hope to have arrived at a firm set of figures in consultation with you and your staff.

Secretarial Priorities

Our budget also reflects continuing emphasis on a number of issues of particular concern to Secretary Bowen, including quality of care information, home health services, Peer Review Organizations, and competition/capitation. While I will discuss the whole area of quality of care below in connection with HCFA's proposed effectiveness initiative, at this point I would like to highlight some of our plans in the other areas of Secretarial interest.

- Home health care is a burgeoning industry whose growth has been fueled both by a real preference on the part of Medicare beneficiaries for home care as well as economic incentives to find alternatives to costly institutional care. Both the Administration and the Congress are eager to ensure that the home health services rendered to our beneficiaries are of high quality. This concern was reflected in the enactment of a number of provisions in OBRA 1987 that will require us to increase survey coverage of home health agencies (HHAs) and impose stiffer conditions of participation, while continuing vigorous enforcement. Funds for implementation of these provisions have been included in our State Survey and Certification request.

  In addition, the catastrophic health insurance legislation as approved by the Congress includes a provision expanding the "intermittent" skilled nursing care definition for home health services so that "daily" would be defined as up to seven days a week for up to 38 days in any given period, instead of five days a week for up to two or three weeks. Estimates of the additional benefit costs entailed will be developed and provided as part of our supplementary FY 1990 package on implementation of the new catastrophic coverage.

- With respect to management of the **Peer Review Organizations**, the new three-year contracting cycle provided for in OBRA 1987 will give HCFA a better opportunity to evaluate performance of individual PROs and to negotiate contracts that address issues specific to particular States.

  In addition, HCFA will be taking the initiative to:

  - implement a new PRO cost reporting form to collect cost data by cost accounting category and type of review, information which has not previously been available under fixed price contracts. This will give us more information for evaluating PRO estimates of the costs of conducting reviews and negotiating prices in future contracts.

  - develop up to five cost reimbursement contract demonstrations in order to explore this alternative method of funding PROs. In addition to helping us to learn how much PRO reviews actually cost, these contracts will hold the PROs more accountable for submitting reports and other deliverables in a timely manner.

- Increasing **competition** and **consumer** choice in the health care marketplace is a continuing concern of the Secretary's and mine. The importance of the Private Health Plan Option is clear throughout our budget request. We will continue our work to facilitate the availability of prepaid plans as an option for Medicare beneficiaries. In addition, our research plans call for investigating the growth of health maintenance organizations and competitive medical plans under the current system and designing demonstration projects to test different capitation systems. We will also be continuing work already begun to examine the advisability of adjustments (e.g., geographic reconfiguration) to the current AAPCC methodology or alternatives (e.g., the diagnostic cost group model) to this methodology.

Effectiveness Initiative

Maintaining and upgrading the quality of care for beneficiaries has had the highest priority throughout the Reagan Administration and continues to be of particular concern to Dr. Bowen and me, as physicians. Recently our efforts in this area have taken on a new focus. During the past several weeks and months, my senior staff and I have had extensive discussions among ourselves and with outside experts on how to redefine the notion of quality care to emphasize the effectiveness of that care.

Up until now, monitoring quality of care has consisted largely of ensuring that care is rendered in safe facilities according to generally accepted standards of medical practice. The goal has been to weed out "bad" doctors and "bad" hospitals (or SNFs or HHAs), who fail in some overt way to provide a reasonable level of care. The use of case review screens by the contractors and PROs and the publication of hospital mortality data are examples of ways in which HCFA has used its resources to help identify outliers in the medical community who may qualify for sanctions based on failure to provide quality care.

This kind of quality review will continue and significant amounts of resources are requested to do so. We are intensifying survey and certification efforts in many types of facilities, in part in response to legislative mandates. We are increasing funding for PROs so that they can do more to identify cases in which inappropriate or unnecessary medical services are being provided. We are also increasing funding for medical review and utilization review by contractors to ensure that only needed services are provided. These kinds of activities not only protect beneficiaries from the risks and expense of medical procedures that are unnecessary, but they also reduce the costs of our programs and make us a more prudent purchaser of medical services.

However, these traditional quality activities do not address a broader issue--whether services provided to our beneficiaries are not only consistent with generally accepted standards of medical practice, but also actually effective in reducing beneficiary mortality, morbidity, and disability. To put it simply, we know too little about what works in medicine.

Therefore, HCFA has included in its FY 1990 budget request a major new effectiveness initiative, building on the start we will have made in FY 1988 and FY 1989. We envision the project with a first-year cost of $50 million, phasing up to $100 million in FY 1991 and $150 million in FY 1992 and beyond (adjusted for inflation after FY 1992). Key elements of the package are as follows:

HCFA Center for Data Linkages and Public Use Information
(FY 1990 cost $20 million)

The HCFA Data Center would develop and implement efficient ways to (1) link Medicare data across services and across years; (2) link Medicare data to other person-level data bases including disability and work history data bases from other agencies; and (3) provide public use information and data files for effectiveness research.

Medicare Beneficiary Health Status Registry
(FY 1990 cost $3 million)

HCFA would create an ongoing epidemiological surveillance system by surveying a five percent sample of new Medicare beneficiaries and following up every five years. Information collected would pertain to medical history, current health status, socio-economic status, etc.

Outcomes Surveillance
(FY 1990 cost $5 million)

Post-hospitalization status reports would gather health and functional status information on patients following hospitalization. This information would supplement the information currently obtained through mortality and rehospitalization data to give a more complete picture of effectiveness of procedures.

Basic and Applied Effectiveness Research and Demonstrations
(FY 1990 cost $20 million)

HCFA would establish consultative mechanisms through which outside experts would advise on needed effectiveness research, research design, and implications of findings for HCFA programs. We would expand on current efforts to analyze medical records and claims data from PROs and train PRO personnel to assist in this effort. We would fund studies of the effectiveness of selected covered services, such as carotid endarterectomy, especially where effectiveness has been questioned. Finally, we would fund studies of the effectiveness of emerging technologies which could prove more cost effective than treatments currently in use and covered by Medicare.

Outreach, Dissemination and Training
(FY 1990 cost $2 million)

HCFA would continue and expand current activities in data dissemination (hospital mortality and small area variations) and improve PRO activities in provider feedback and evaluation. We would also establish mechanisms for systematic dissemination of effectiveness information to the medical community. One possible avenue would be the creation of HCFA fellowship programs to train physicians in effectiveness research and its applications.

While considerable resources would need to be devoted in the early years to developing the systems capacity and data linkages needed for effectiveness research, once these systems were in place we would expect to devote a larger proportion of effectiveness funds to intramural and extramural studies of the effectiveness of particular procedures, drugs, and devices. Once a body of research findings began to emerge, the dissemination and training function would take on increased importance.

In the long run, the process we would set in motion would put the Department of Health and Human Services in a leadership role in developing and disseminating scientific and empirically based information regarding the cost-effectiveness of alternative treatment modalities. It is imperative that we do so, both to conserve the taxpayers' dollars and to guarantee our beneficiaries the best available medical care.

Program Benefits Request

Under current law, both Medicare benefits and Medicaid are expected to increase substantially in FY 1990. In Medicaid, benefit and administrative outlays will be 9.4 percent higher in FY 1990, based on two key assumptions: (1) a 0.5 percent reduction in the May State estimates, as in the FY 1989 budget and (2) a repricing of the FY 1989 initiatives based on updated information. We are sending forward as a legislative initiative the Medicaid restructuring proposal that has been under discussion in the department for some time. However, we do not view it as a budget proposal, but rather as a budget neutral reform package that would rectify certain distributional inequities among the States and establish the principle of prospective budgeting for Medicaid.

Medicare benefits will increase 12.5 percent in FY 1990 under current law, based on the most recent (Midsession) base re-estimates, with Part A up 11.8 percent and Part B up 13.5 percent. This latest revision reflected increases in the number of enrollees, increased benefits per enrollee, and a greater intensity and utilization of health services. Partly offsetting these increases, we are proposing Medicare benefit savings and income increases totaling over $4.9 billion or almost 5 percent of benefit outlays. These proposals include: (1) resubmittal of FY 1989 savings proposals (estimated to save

$1.5 billion in FY 1990), (2) resubmittal of FY 1989 income proposals (estimated to increase income by $2.0 billion in FY 1990), (3) a proposal to extend the provision of present law that reduces payments made on a reasonable cost basis to hospitals for capital expenditures by 15% (estimated to save $0.9 billion in FY 1990), and (4) new savings proposals focusing primarily on slowing the rapid growth in Part B spending (estimated to save $0.5 billion in FY 1990).

We resisted the temptation to rely on the Part A program for virtually all major new savings. As you know, the bulk of the savings achieved to date have come from Part A. For FY 1990, we believe Part B should bear a larger proportion. Only 20 percent of the savings from our new FY 1990 proposals result from reductions in Part A outlays. Requiring hospitals and other Part A providers to bear a disproportionate share of the reductions, when spending for physicians and suppliers in Part B continues to escalate virtually unchecked, would not be prudent. The savings from our new proposals plus the extension of the current capital provision will exceed by a considerable margin the HCFA FY 1990 savings target of $1.0 billion; this excess is intended to offset increases in our program management account (described below).

Program Management

While program management expenditures comprise only a small fraction of HCFA's total expenditures, they are critical to our success in carrying out some of our most important initiatives. For example, efforts to improve quality of care and to develop information on the relative effectiveness of medical services are funded almost entirely from this program management account.

A brief description of our request for each major component of the program management account follows.

o Peer Review Organizations

This budget request closely conforms to the recent PRO third round apportionment request, which is currently under review in your office. This funding level will result in outlays at or below the President's Budget projections through FY 1990.

The total third round request is $1.26 billion for the period FY 1988 through FY 1993. The FY 1990 funding level of $254.5 million is well under half of the anticipated FY 1989 level. This is because we will incur most of the third round obligations in FY 1989 and none of the fourth round obligations until FY 1991.

o Research, Demonstrations, and Evaluations

The centerpiece of our research request is the funding requested for effectiveness activities, described at length above. We are requesting a total of $61.0 million for research activities, with $25.0 million of this earmarked for effectiveness research and demonstrations and related activities. The remaining $36 million would be used to continue and expand our study of:

- -- refinement and reform of the current Medicare physician payment system through the study of the causes for the growth in Medicare outlays for physician services and the testing of alternative payment/delivery systems such as preferred provider organizations, Medicare insured groups, etc;
- -- continued availability of quality care under Medicare and Medicaid and improved methods for measuring quality of care, and;
- -- increased competition and consumer choice and continued growth of the private health plan option.

While this requested level of funding is well above the $32.6 million planning target, we believe that HCFA spending for research has been altogether too low for many years. In part, this pattern has reflected unwarranted reductions below the levels requested. However, it may also be true that our agency has set its sights too low in this critical area. This FY 1990 budget represents an opportunity for us to make an important statement about the need for a strong research program to keep pace with structural change in health care delivery and financing.

o Medicare Contractors

HCFA's FY 1990 budget request for Medicare Contractors is $1,611.5 million, plus a $40 million contingency fund. Again, our request significantly exceeds the planning target of $1,474.1 million. Major components of the increase over FY 1989 spending levels are:

- -- claims volume increases ($80.5 million)
- -- implementation of the common working file ($34.9 million)
- -- expansion of payment safeguards ($43.3 million)
- -- increased hearings workload ($19.0 million)

We have requested a contingency fund for FY 1990 to prepare for possible unforeseen workloads.

- State Certification

  Funding needed for State Certification in FY 1990 is expected to be much higher than in FY 1989. More precisely, we are requesting $99.1 million for FY 1990, which is $32.0 million over the planning target of $67.1 million. These resources are needed to:

  -- implement several major OBRA provisions, including an enhanced survey process and enforcement activities in HHAs and nursing facilities and certification of high volume physician office laboratories ($19.5 million)

  -- increase our coverage level for clinical laboratories from 60 percent to 100 percent ($3.8 million)

  -- expand the certification program to survey 881 new providers and suppliers ($3.3 million)

  -- increase contract support to assist with training, surveying of psychiatric hospitals, etc. ($2.9 million)

  -- provide inflation cost of living increases for the State surveyors ($2.4 million)

  -- purchase laptop computers for State surveyors ($4.0 million), which is expected to save approximately $3.0 million through increased productivity.

Administrative Costs

For FY 1989, we are seeking a revision to enable the transfer of the HI/SMI automated data processing workload from the Social Security Administration to HCFA. The revised request also reflects the absorption of the FY 1989 anticipated pay raise costs and the reduction of monies collected from HMOs seeking Federal qualification. Our revised estimate for FY 1989 is $283.1 million, $12.0 million above the President's Budget request of $271.1 million.

For FY 1990, the request maintains the administrative activity level proposed for FY 1989 as well as supports the effectiveness initiative and certain other new workload demands. The total request for FY 1990 is $307.1 million, $34.4 million over the planning target of $272.7. The largest components of the increase over FY 1989 spending are:

- funds to support the effectiveness initiative ($25.0 million)
- monies associated with the addition of 35 FTEs to meet new workload demands and 86 FTEs for Medicare hearings and appeals activities ($5.5 million)
- funds for employee within grade increases and annualization of the FY 1989 proposed pay raise ($1.9 million)
- costs for GSA, postal and inflationary increases ($2.8 million)
- costs for maintenance, supplies, and telecommunications resulting from additional ADP equipment scheduled to be used throughout the agency in FY 1990 ($1.0 million)

HCFA is requesting an FTE ceiling of 4,292 in FY 1990. This request will provide 3,927 FTEs for ongoing operations, 125 FTEs to implement catastrophic coverage under Medicare and 240 FTEs for Medicare hearings and appeals activities. HCFA's request of 3,927 FTEs for ongoing operations is 35 over the FY 1989 FTE base of 3,892.

HCFA has reached the point where it can no longer absorb FTE reductions or increased workload demands and still effectively do its job. This is especially alarming considering the current Administration and congressional emphasis on HCFA's programs. Without the requested increase in ceiling, there will be a negative impact on HCFA's ability to fulfill its current program objectives.

Conclusion

The FY 1990 budget offers the Reagan Administration a final opportunity to express in the most concrete possible way--through allocation of dollars and cents--its views on the most pressing problems facing health care delivery and financing in America and the most promising avenues to solutions to these problems. HCFA's FY 1990 budget request acknowledges that HCFA needs to redirect and expand the scope of its activities so that it is less a passive mechanism for payment of medical bills and more of a participant in the development and dissemination of information about the most effective ways to treat the diseases and conditions most common among our beneficiary population.

This new emphasis for HCFA would build on our progress to date in upgrading the quality of care. As expensive new devices, procedures, and drugs become increasingly available, we must learn to target our health care dollars on those treatments that have been demonstrated to be effective. This can happen only if physicians and other health care practitioners have access to the best possible scientific information about effective treatment.

HCFA's budget request takes this long-range view by shifting resources into a phased in effectiveness program, with data development, systematic research, and dissemination and training as its key elements. We look forward to discussing these ideas with you and responding to any questions you may have about our budget request over the coming weeks.

HEALTH CARE FINANCING ADMINISTRATION

FY 1990 BUDGET AND LEGISLATIVE PROGRAM

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BUDGET SUMMARY
($ in Millions)
Including Proposed Legislation

	FY 1988	FY 1989			FY 1990		
	Current Estimate	Pres' Budget	Current Estimate	Difference	Planning Target	HCFA Request	Difference
Grants to States 1/ for Medicaid	$ 30,818.6	$ 32,732.6	$ 33,495.6	$ 763.0	$ 35,834.6	$ 36,659.4	$ 824.8
Pymts to Health 1/ Care Trust Funds	26,437.0	32,436.0	32,367.0	(69.0)	34,467.0	34,458.0	(9.0)
Supplementary 1/ Medical Insurance	35,069.3	39,688.6	39,780.1	91.5	44,681.2	44,342.7	(338.5)
PROs (non-add)	[18.9]	[64.7]	[67.5]	(0.1)	[64.3]	[64.2]	(0.1)
ESRD Networks (non-add)	[6.6]	[7.1]	[7.1]	—	[7.6]	[7.6]	—
Federal Hospital 1/ Insurance	53,117.2	54,802.1	56,916.2	2,114.1	60,754.1	61,553.1	799.0
PROs (non-add)	[170.5]	[257.4]	[254.0]	(0.2)	[242.0]	[241.6]	(0.3)
Program Management							
Research	26.8	32.0	32.0	—	32.6	61.0	28.4
M'care Contractors 2/	1,181.6	1,391.0	1,391.0	—	1,474.1	1,611.5	137.4
Conting. Fund (non-add)	—	—	—	—	—	[40.0]	[40.0]
State Certification	65.8	65.8	65.8	—	67.1	99.1	32.0
Administrative Costs	252.8 3/	271.1	283.1 5/	12.0 4/	272.7	307.1 5/	34.4
Total Obligations, Program Management	$ 1,527.0	$ 1,759.9	$ 1,771.9	$ 12.0	$ 1,846.5	$ 2,078.7	$ 232.2
FTEs	3,829	4,046	4,171	125 6/	3,982	4,292	310
HMO User Fees	$ 1.6	$ 1.6	$ .3	$ (1.3)	$ 1.6	$ .3	$ (1.3)
Catastrophic	$ 47.9	$ 112.4	$ 160.0	$ 47.6	$ —	$ 305.0	$ 305.0
HMO Loans	—	—	$ 5.0	$ 5.0	—	$ 5.0	$ 5.0

1/ Outlays 2/ Includes NOU transfer from SSA
3/ Reflects the travel reduction of $1,038,000 as required in the FY 1988 Continuing Resolution.
4/ Reflects the transfer of the HI/SMI ADP workload from SSA.
5/ Excludes funds for Catastrophic Health Insurance.
6/ FTEs associated with Catastrophic Health Insurance.

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FY 1990

HEALTH CARE FINANCING ADMINISTRATION

OVERVIEW

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10-Jun-88

FY 1990 Department Submission

HCFA Division of Budget

Date last calculated 6/10/88
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	FY 1988	* ** ** ** **	FY 1989	* ** ** ** **	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
		PRIOR ESTIMATE	CHANGE	CURRENT ESTIMATE					
TOTAL BUDGET AUTHORITY									
1) MEDICAID									
a) CURRENT LAW	30,811,859	32,732,589	762,958	33,495,547	36,639,442	39,397,919	43,195,397	47,082,499	51,162,774
b) PROPOSED LAW	0	0	0	0	20,000	50,000	80,000	125,000	190,000
SUBTOTAL	30,811,859	32,732,589	762,958	33,495,547	36,659,442	39,447,919	43,275,397	47,207,499	51,352,774
2) PROGRAM MANAGEMENT									
a) CURRENT LAW	98,211	95,246	1,274	96,520	101,797	106,220	111,345	112,852	114,287
b) PROPOSED LAW	0	0	0	0	0	0	0	0	0
SUBTOTAL	98,211	95,246	1,274	96,520	101,797	106,220	111,345	112,852	114,287
3) HMO LOAN & LOAN GUARANTEE									
a) CURRENT LAW	0	0	0	0	0	0	0	0	0
b) PROPOSED LAW	0	0	0	0	0	0	0	0	0
SUBTOTAL	0	0	0	0	0	0	0	0	0
4) HOSPITAL INSURANCE									
a) CURRENT LAW	68,020,500	72,794,000	173,747	72,967,747	78,531,837	84,299,000	89,694,900	95,527,100	101,779,000
b) PROPOSED LAW	0	1,660,000	(1,660,000)	0	1,432,000	2,241,000	2,562,000	2,756,000	2,971,000
SUBTOTAL	68,020,500	74,454,000	(1,486,253)	72,967,747	79,963,837	86,540,000	92,256,900	98,283,100	104,750,000
5) SUPPLEMENTARY MEDICAL INSURANCE									
a) CURRENT LAW	34,846,000	42,855,000	(428,000)	42,427,000	46,452,000	52,856,000	60,187,000	68,402,000	77,870,000
b) PROPOSED LAW	0	(285,000)	285,000	0	(26,000)	64,000	(273,000)	(69,000)	(933,000)
SUBTOTAL	34,846,000	42,570,000	(143,000)	42,427,000	46,426,000	52,920,000	59,914,000	68,333,000	76,937,000
TOTAL B.A. CURRENT LAW	133,776,570	148,476,835	509,979	148,986,814	161,725,076	176,659,139	193,188,642	211,124,451	230,925,061
TOTAL B.A. PROPOSED LAW	0	1,375,000	(1,375,000)	0	1,426,000	2,355,000	2,369,000	2,812,000	2,228,000
TOTAL B.A. NET PROPOSED LAW	133,776,570	149,851,835	(865,021)	148,986,814	163,151,076	179,014,139	195,557,642	213,936,451	233,154,061

08:30 AM

Date last calculated 6/10/88 Time last calculated 8:30 AM	FY 1988	* ** ** ** **	FY 1989	* ** ** ** **	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
		PRIOR ESTIMATE	CHANGE	CURRENT ESTIMATE					
TOTAL OUTLAYS									
1) MEDICAID									
a) CURRENT LAW	30,818,559	32,732,589	762,958	33,495,547	36,639,442	39,397,919	43,195,397	47,082,499	51,162,774
b) PROPOSED LAW	0	0	0	0	20,000	50,000	80,000	125,000	190,000
SUBTOTAL	30,818,559	32,732,589	762,958	33,495,547	36,659,442	39,447,919	43,275,397	47,207,499	51,352,774
2) PROGRAM MANAGEMENT									
a) CURRENT LAW	100,803	90,808	9,235	100,043	99,361	103,085	107,348	108,692	109,981
b) PROPOSED LAW	0	0	0	0	0	0	0	0	0
SUBTOTAL	100,803	90,808	9,235	100,043	99,361	103,085	107,348	108,692	109,981
3) HMO LOAN & LOAN GUARANTEE									
a) CURRENT LAW	0	0	0	0	0	0	0	0	0
b) PROPOSED LAW	0	0	0	0	0	0	0	0	0
SUBTOTAL	0	0	0	0	0	0	0	0	0
4) HOSPITAL INSURANCE									
a) CURRENT LAW	53,117,246	55,782,093	1,134,136	56,916,229	63,673,125	70,256,771	76,972,691	83,638,496	90,937,707
b) PROPOSED LAW	0	(980,000)	980,000	0	(2,120,000)	(3,146,000)	(3,466,000)	(3,777,000)	(4,112,000)
SUBTOTAL	53,117,246	54,802,093	2,114,136	56,916,229	61,553,125	67,110,771	73,506,691	79,861,496	86,825,707
5) SUPPLEMENTARY MEDICAL INSURANCE									
a) CURRENT LAW	35,069,257	40,025,586	(245,503)	39,780,083	45,139,717	51,560,839	59,063,951	67,423,839	76,976,136
b) PROPOSED LAW	0	(337,000)	337,000	0	(797,000)	(1,562,000)	(1,992,000)	(2,457,000)	(3,088,000)
SUBTOTAL	35,069,257	39,688,586	91,497	39,780,083	44,342,717	49,998,839	57,071,951	64,966,839	73,888,136
TOTAL OUTLAYS, CURRENT LAW	119,105,865	128,631,076	1,660,826	130,291,902	145,551,645	161,318,614	179,339,387	198,253,526	219,186,598
TOTAL OUTLAYS, PROPOSED LAW	0	(1,317,000)	1,317,000	0	(2,897,000)	(4,658,000)	(5,378,000)	(6,109,000)	(7,010,000)
TOTAL OUTLAYS, NET PROPOSED LAW	119,105,865	127,314,076	2,977,826	130,291,902	142,654,645	156,660,614	173,961,387	192,144,526	212,176,598

Date last calculated 6/10/88
Time last calculated 8:30 AM

	FY 1988	* ** ** ** ** PRIOR ESTIMATE	FY 1989 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
TOTAL OUTLAYS NET OF OFFSETTING RECEIPTS									
1) MEDICAID									
a) CURRENT LAW	30,818,559	32,732,589	762,958	33,495,547	36,639,442	39,397,919	43,195,397	47,082,499	51,162,774
b) PROPOSED LAW	0	0	0	0	20,000	50,000	80,000	125,000	190,000
SUBTOTAL	30,818,559	32,732,589	762,958	33,495,547	36,659,442	39,447,919	43,275,397	47,207,499	51,352,774
2) PROGRAM MANAGEMENT									
a) CURRENT LAW	100,803	90,808	9,235	100,043	99,361	103,085	107,348	108,692	109,981
b) PROPOSED LAW	0	0	0	0	0	0	0	0	0
SUBTOTAL	100,803	90,808	9,235	100,043	99,361	103,085	107,348	108,692	109,981
3) HMO LOAN & LOAN GUARANTEE									
a) CURRENT LAW	0	0	0	0	0	0	0	0	0
b) PROPOSED LAW	0	0	0	0	0	0	0	0	0
SUBTOTAL	0	0	0	0	0	0	0	0	0
4) HOSPITAL INSURANCE									
a) CURRENT LAW	53,070,246	55,728,093	1,133,136	56,861,229	63,614,125	70,191,771	76,903,691	83,565,496	90,860,707
b) PROPOSED LAW	0	(980,000)	980,000	0	(2,120,000)	(3,146,000)	(3,466,000)	(3,777,000)	(4,112,000)
SUBTOTAL	53,070,246	54,748,093	2,113,136	56,861,229	61,494,125	67,045,771	73,437,691	79,788,496	86,748,707
5) SUPPLEMENTARY MEDICAL INSURANCE									
a) CURRENT LAW	26,343,257	29,516,586	(158,503)	29,358,083	33,867,717	39,604,839	46,448,951	54,184,839	63,082,136
b) PROPOSED LAW	0	(250,000)	250,000	0	(1,427,000)	(3,132,000)	(4,232,000)	(6,187,000)	(8,588,000)
SUBTOTAL	26,343,257	29,266,586	91,497	29,358,083	32,440,717	36,472,839	42,216,951	47,997,839	54,494,136
TOTAL OUTLAYS NET OFFSETTING RECEIPTS, CURRENT LAW	110,332,865	118,068,076	1,746,826	119,814,902	134,220,645	149,297,614	166,655,387	184,941,526	205,215,598
TOTAL OUTLAYS NET OFFSETTING RECEIPTS, PROPOSED LAW	0	(1,230,000)	1,230,000	0	(3,527,000)	(6,228,000)	(7,618,000)	(9,839,000)	(12,510,000)
TOTAL OUTLAYS NET OFFSETTING RECEIPTS, NET PROPOSED LAW	110,332,865	116,838,076	2,976,826	119,814,902	130,693,645	143,069,614	159,037,387	175,102,526	192,705,598

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TOTAL APPROPRIATION									
1) MEDICAID									
a) CURRENT LAW	30,811,859	32,732,589	762,958	33,495,547	36,639,442	39,397,919	43,195,397	47,082,499	51,162,774
b) PROPOSED LAW	0	0	0	0	20,000	50,000	80,000	125,000	190,000
SUBTOTAL	30,811,859	32,732,589	762,958	33,495,547	36,659,442	39,447,919	43,275,397	47,207,499	51,352,774
2) PROGRAM MANAGEMENT									
a) CURRENT LAW	98,211	95,246	1,274	96,520	101,797	106,220	111,345	112,852	114,287
b) PROPOSED LAW	0	0	0	0	0	0	0	0	0
SUBTOTAL	98,211	95,246	1,274	96,520	101,797	106,220	111,345	112,852	114,287
3) HMO LOAN & LOAN GUARANTEE									
a) CURRENT LAW	0	0	0	0	0	0	0	0	0
b) PROPOSED LAW	0	0	0	0	0	0	0	0	0
SUBTOTAL	0	0	0	0	0	0	0	0	0
4) PAYMENTS TO HEALTH CARE TRUST FUNDS									
a) CURRENT LAW	25,893,000	32,100,000	(293,000)	31,807,000	34,751,000	40,355,000	46,929,000	54,438,000	63,175,000
b) PROPOSED LAW	0	(205,000)	205,000	0	(663,000)	(1,532,000)	(2,531,000)	(3,817,000)	(6,449,000)
SUBTOTAL	25,893,000	31,895,000	(88,000)	31,807,000	34,088,000	38,823,000	44,398,000	50,621,000	56,726,000
TOTAL APPROPRIATION, CURRENT LAW	56,803,070	64,927,835	471,232	65,399,067	71,492,239	79,859,139	90,235,742	101,633,351	114,452,061
TOTAL APPROPRIATION, PROPOSED LAW	0	(205,000)	205,000	0	(643,000)	(1,482,000)	(2,451,000)	(3,692,000)	(6,259,000)
TOTAL APPROPRIATION, NET P.L.	56,803,070	64,722,835	676,232	65,399,067	70,849,239	78,377,139	87,784,742	97,941,351	108,193,061

Date last calculated 6/10/88 Time last calculated 8:30 AM	FY 1988	* ** ** ** ** PRIOR ESTIMATE	FY 1989 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
CURRENT LAW									
GRANTS TO STATES FOR MEDICAID									
1) MEDICAL ASSISTANCE PAYMENTS									
a) State Estimates (5/88)	29,254,594	31,683,706	546,401	32,230,107	35,027,483	37,514,246	41,003,486	44,707,304	48,814,000
Adjustments	(146,273)	(200,419)	(2,732)	(203,151)	(175,137)	0	0	0	0
MEDICAL ASSISTANCE, ADJUSTED	29,108,321	31,483,287	543,669	32,026,956	34,852,346	37,514,246	41,003,486	44,707,304	48,814,000
b) Prior Year Claims	6,700	0	0	0	0	0	0	0	0
c) MQC Dis includes Withholding	0	(3,800)	0	(3,800)	(19,600)	(189,200)	(85,200)	(40,000)	(40,000)
d) Financial Adjustments	107,021	0	0	0	0	0	0	0	0
e) Medicaid Initiatives	(72,700)	(721,250)	209,750	(511,500)	(591,000)	(666,000)	(742,000)	(831,000)	(899,000)
f) Immigration Reform	0	0	0	0	0	0	0	0	0
g) OBRA '87 Impact - See detail	71,000	310,000	(14,000)	296,000	625,000	877,000	1,106,000	1,292,000	1,292,000
SUBTOTAL, MEDICAL ASSISTANCE OUT.	29,220,342	31,068,237	739,419	31,807,656	34,866,746	37,536,046	41,282,286	45,128,304	49,167,000
SUBTOTAL,OBL.WHERE DIFF.FROM OUT.									
2) STATE AND LOCAL ADMINISTRATION									
a) State Estimates (5/88)	1,525,131	1,580,840	37,669	1,618,509	1,686,353	1,745,400	1,797,800	1,840,900	1,885,100
b) Financial & Other Adjustments	(21,627)	(7,904)	(189)	(8,093)	(8,432)	(8,727)	(8,989)	(9,205)	(9,426)
c) Immigration Reform	0	0	0	0	0	0	0	0	0
d) Cost Allocation Savings	0	(11,000)	0	(11,000)	(11,000)	(9,000)	(9,000)	(9,000)	(9,000)
e) MMIS Funding Restrict (BQC59P)	0	0	(17,600)	(17,600)	(18,300)	(18,900)	(19,500)	(20,000)	(20,500)
SUBTOTAL, S&L ADMINISTRATION	1,503,504	1,561,936	19,880	1,581,816	1,648,621	1,708,773	1,760,311	1,802,695	1,846,174
3) STATE CERTIFICATION									
a) State Estimates (5/88)	49,260	51,711	1,159	52,870	56,570	58,500	60,300	61,700	63,200
b) OBRA '87 Impact	0	3,000	2,500	5,500	19,800	45,200	41,600	37,700	33,000
SUBTOTAL, STATE CERTIFICATION	49,260	54,711	3,659	58,370	76,370	103,700	101,900	99,400	96,200
4) FRAUD CONTROL UNITS									
a) State Estimates (5/88)	45,453	47,705	0	47,705	47,705	49,400	50,900	52,100	53,400
SUBTOTAL, FRAUD CONTROL UNITS	45,453	47,705	0	47,705	47,705	49,400	50,900	52,100	53,400
SUBTOTAL, ALL ADMIN (2-4). OUT.	1,598,217	1,664,352	23,539	1,687,891	1,772,696	1,861,873	1,913,111	1,954,195	1,995,774
SUBTOTAL,OBL.WHERE DIFF.FROM OUT.									
TOTAL OBLIGATIONS/OUTLAYS C.L.	30,818,559	32,732,589	762,958	33,495,547	36,639,442	39,397,919	43,195,397	47,082,499	51,162,774
TOTAL OBL.WHERE DIFF.FROM OUT.									
UNOBLIGATED BALANCE									
o BOY - Regular	0	0	0	0	0	0	0	0	0
o BOY - Prior Year Claims	(6,700)	0	0	0	0	0	0	0	0
o EOY - Expired Accts Returned	0	0	0	0	0	0	0	0	0
o EOY - Prior Year Claims	0	0	0	0	0	0	0	0	0
APPROPRIATION/ BA	30,811,859	32,732,589	762,958	33,495,547	36,639,442	39,397,919	43,195,397	47,082,499	51,162,774
APPROPRIATION WHERE DIF. FROM BA									
INDEFINITE APPRO (NO-ADD)	765,859								
o Advanced Appropriation	7,100,000	8,000,000	0	8,000,000	9,200,000	9,900,000	10,800,000	11,800,000	12,800,000
o Remaining Appropriation	22,946,000	24,732,589	762,958	25,495,547	27,439,442	29,497,919	32,395,397	35,282,499	38,362,774

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		PRIOR ESTIMATE	CHANGE	CURRENT ESTIMATE					
GRANTS TO STATES FOR MEDICAID									
PROPOSED LAW-MAP									
1) Senate Finance-Catastrophic Bill	0	0	0	0	0	0	0	0	0
2)Mcaid impact/SMI premium proposal	0	0	0	0	20,000	50,000	80,000	125,000	190,000
Total B.A./Outlays Proposed law	0	0	0	0	20,000	50,000	80,000	125,000	190,000
TOTAL APPROPRIATION / BA, NET P.L.	30,811,859	32,732,589	762,958	33,495,547	36,659,442	39,447,919	43,275,397	47,207,499	51,352,774
APPR. WHERE DIF. FROM BA, NET P.L.									
TOTAL OUTLAYS NET P.L.	30,818,559	32,732,589	762,958	33,495,547	36,659,442	39,447,919	43,275,397	47,207,499	51,352,774
MEDICAID INITIATIVES - DETAIL									
1) Second Surgical Opinion Prog	0	(15,000)	0	(15,000)	(30,000)	(30,000)	(30,000)	(30,000)	(30,000)
2) Prescript Drug Reform(BERC356F)	0	(60,000)	60,000	0	0	0	0	0	0
3) Medicaid Fin. Mgt. Reviews	(62,700)	(193,000)	0	(193,000)	(170,000)	(187,000)	(206,000)	(227,000)	(250,000)
5) Pymts to Instit (BERC514F)	(10,000)	(35,000)	0	(35,000)	(50,000)	(60,000)	(70,000)	(80,000)	(80,000)
6) LTC Cond (BERC396P)-in OBRA #2	0	0	0	0	0	0	0	0	0
7) Med Need Inc Level (BERC179P)	0	(45,000)	22,500	(22,500)	(45,000)	(45,000)	(45,000)	(45,000)	(45,000)
8) Limit Donations (BQC70P)	0	(176,000)	0	(176,000)	(186,000)	(196,000)	(206,000)	(216,000)	(216,000)
9) MMIS Funding Restrict (BQC59P)	0	(61,000)	43,400	(17,600)	(18,300)	(18,900)	(19,500)	(20,000)	(20,500)
10) Survey and Cert. Disallowances	0	(5,000)	5,000	0	0	0	0	0	0
11) State Tax Disallowances	0	0	0	0	0	0	0	0	0
12) Liens/Recoveries	0	(70,000)	50,000	(20,000)	(40,000)	(70,000)	(100,000)	(140,000)	(180,000)
13) Ambulatory Surgery	0	(22,000)	7,000	(15,000)	(30,000)	(35,000)	(40,000)	(45,000)	(50,000)
14) End FFP for Non Med Svc(ICF/MR	0	(30,000)	0	(30,000)	(30,000)	(33,000)	(35,000)	(38,000)	(38,000)
15) Pread Test/Same Day Surg	0	(9,250)	4,250	(5,000)	(10,000)	(10,000)	(10,000)	(10,000)	(10,000)
Total Initiatives	(72,700)	(721,250)	192,150	(529,100)	(609,300)	(684,900)	(761,500)	(851,000)	(919,500)

OBRA '87 - DETAIL									
1) Pregnant Women/Children	30,000	140,000	0	140,000	205,000	275,000	330,000	380,000	380,000
2) Nursing Home Quality	0	59,000	0	59,000	138,000	213,000	287,000	318,000	318,000
3) New Survey/Cert Requiremts	0	3,000	2,500	5,500	19,800	45,200	41,600	37,700	33,000
4) Incrd pmt for DSH	15,000	40,000	0	40,000	60,000	60,000	60,000	60,000	60,000
5) Limit on HCB Waivers	0	0	0	0	150,000	250,000	350,000	450,000	450,000
6) Adj Income Levels - CA couples	15,000	5,000	0	5,000	5,000	5,000	5,000	5,000	5,000
7) Incrd pmt to territories	0	14,000	(14,000)	0	0	0	0	0	0
8) Clinic svcs to homeless	10,000	15,000	0	15,000	20,000	20,000	20,000	20,000	20,000
9) AFDC/SSI deemg; Katy B.tech	6,000	17,000	0	17,000	17,000	24,000	24,000	24,000	24,000
10) MQC Moratorium	0	0	0	0	0	0	0	0	0
11) Mcaid Impact of Medicare prov	(5,000)	20,000	0	20,000	30,000	30,000	30,000	35,000	35,000
Total OBRA '87	71,000	313,000	(11,500)	301,500	644,800	922,200	1,147,600	1,329,700	1,325,000

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	FY 1988	* ** ** ** **	FY 1989	* ** ** ** **	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
		PRIOR ESTIMATE	CHANGE	CURRENT ESTIMATE					
PROGRAM MANAGEMENT, CURRENT LAW									
PEER REVIEW ORGANIZATIONS:OBLIG	377,438	318,750	311,670	630,420	254,478	303,714	608,531	300,531	356,633
ESRD NETWORKS: OBLIG\OUTLAY	6,613	7,087	(11)	7,076	7,571	8,101	8,668	9,275	9,924
BUDGET AUTHORITY									
1) RESEARCH									
a) Program Level	26,807	32,000	0	32,000	61,000	103,188	145,229	149,295	152,729
b) Less Trust Fund Transfer	(17,233)	(20,571)	0	(20,571)	(47,000)	(86,000)	(124,000)	(127,472)	(130,404)
RESEARCH B.A. - BPS	9,574	11,429	0	11,429	14,000	17,188	21,229	21,823	22,325
2) MEDICARE CONTRACTORS									
2A) Claims Processing									
a) Program Level	826,617	922,500	9,500	932,000	1,082,000	1,335,618	1,626,408	1,957,558	2,346,774
b) Less Trust Fund Transfer	(826,617)	(922,500)	(9,500)	(932,000)	(1,082,000)	(1,335,618)	(1,626,408)	(1,957,558)	(2,346,774)
Claims Processing B.A.	0	0	0	0	0	0	0	0	0
2B) Payment Safeguards									
a) Program Level	300,100	403,100	5,600	408,700	452,000	468,724	484,192	497,749	509,197
b) Less Trust Fund Transfer	(300,100)	(403,100)	(5,600)	(408,700)	(452,000)	(468,724)	(484,192)	(497,749)	(509,197)
Payment Safeguards B.A.	0	0	0	0	0	0	0	0	0
2C) Productivity Investments									
a) Program Level	54,900	65,400	(15,100)	50,300	77,500	80,058	82,300	84,193	86,129
b) Less Trust Fund Transfer	(54,900)	(65,400)	15,100	(50,300)	(77,500)	(80,058)	(82,300)	(84,193)	(86,129)
Productivity Investments B.A.	0	0	0	0	0	0	0	0	0
2D) Contingency Fund (non-add)	0	0	0	0	40,000	40,000	40,000	40,000	40,000
2E) NOU trans fm SSA (non-add)	2,100	0		0	0	0	0	0	0
2F) COBRA Funds (non-add)	100,527	0	0	0	0	0	0	0	0
a) Total CONTRACTOR Program Level	1,181,617	1,391,000	0	1,391,000	1,611,500	1,884,400	2,192,900	2,539,500	2,942,100
b) Less Total Trust Fund Transfer	(1,181,617)	(1,391,000)	0	(1,391,000)	(1,611,500)	(1,884,400)	(2,192,900)	(2,539,500)	(2,942,100)
TOTAL CONTRACTOR B.A.	0	0	0	0	0	0	0	0	0
3) STATE CERTIFICATION									
a) Program Level	65,859	65,859	0	65,859	99,113	102,582	105,659	108,195	110,792
b) Less Trust Fund Transfer	(57,922)	(62,235)	0	(62,235)	(92,555)	(95,794)	(98,668)	(101,036)	(103,461)
STATE CERTIFICATION B.A.	7,937	3,624	0	3,624	6,558	6,788	6,991	7,159	7,331
SUBTOTAL:SCert/Admin-BPS	88,637			85,091	87,797	89,032	90,116	91,029	91,962

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PROGRAM MANAGEMENT, CURRENT LAW (CONT)									
4) ADMINISTRATION COSTS									
a) Pay	174,962	182,249	2,708	184,957	192,323	192,323	192,323	192,323	192,323
b) Non-pay	78,865	88,851	9,300	98,151	114,760	118,547	121,866	124,669	127,536
c) Program Level (a+b)	253,827	271,100	12,008	283,108	307,083	310,870	314,189	316,992	319,859
d) Less Trust Fund Transfer	(171,570)	(189,350)	(12,008)	(201,358)	(225,561)	(228,343)	(230,781)	(232,839)	(234,945)
e) User Fee	(1,557)	(1,557)	1,274	(283)	(283)	(283)	(283)	(283)	(283)
ADMINISTRATIVE COSTS B.A. *bps	80,700	80,193	1,274	81,467	81,239	82,244	83,125	83,870	84,631
5) CONTINGENCY FUNDS (NON-ADD)									
5A) MEDICARE CONTRACTORS									
a) Program Level	0	0	0	0	40,000	40,000	40,000	40,000	40,000
b) Less Trust Fund Transfer	0	0	0	0	(40,000)	(40,000)	(40,000)	(40,000)	(40,000)
Medicare Contractors	0	0	0	0	0	0	0	0	0
5B) CATASTROPHIC IMPLEMENTATION									
a) Program Level	47,870	112,400	47,600	160,000	305,000	533,000	547,924	560,526	573,418
b) Less Trust Fund Transfer	(47,870)	(112,400)	(47,600)	(160,000)	(305,000)	(533,000)	(547,924)	(560,526)	(573,418)
Program Management	0	0	0	0	0	0	0	0	0
a) Total CONTINGENCY Program Level	47,870	0	160,000	160,000	345,000	573,000	587,924	600,526	613,418
b) Less Total Trust Fund Transfer	(47,870)	0	(160,000)	(160,000)	(345,000)	(573,000)	(587,924)	(600,526)	(613,418)
TOTAL CONTINGENCY B.A.(non-add)	0	0	0	0	0	0	0	0	0
TOTAL PROG LEVEL	1,528,110	1,759,959	12,008	1,771,967	2,078,696	2,401,040	2,757,977	3,113,982	3,525,480
TOTAL TRUST FUND TRANSFER	(1,428,342)	(1,663,156)	(12,008)	(1,675,164)	(1,976,616)	(2,294,537)	(2,646,349)	(3,000,847)	(3,410,910)
TOTAL PROGRAM MANAGEMENT B.A.	98,211	95,246	1,274	96,520	101,797	106,220	111,345	112,852	114,287
ADJUSTMENTS : TRAVEL, ETC.	(330)	0	0	0	0	0	0	0	0
TOTAL OBLIGATIONS WHERE DIF FROM BA	97,881								
GENERAL FUND OUTLAYS									
1) RESEARCH - BPS	12,430	9,813	3,330	13,143	11,200	13,750	16,983	17,458	17,860
2) STATE CERTIFICATION	4,445	3,502	(1,328)	2,174	3,672	3,801	3,915	4,009	4,105
3) ADMINISTRATIVE COSTS	83,928	77,493	7,233	84,726	84,489	85,534	86,450	87,225	88,016
SUBTOTAL - Scert/Admin BPS	88,373			86,900	88,161	89,335	90,365	91,234	92,121
TOTAL PROGRAM MANAGEMENT OUTLAYS	100,803	90,808	9,235	100,043	99,361	103,085	107,348	108,692	109,981
PROGRAM MANAGEMENT USER FEE OUTLAYS	1,557	1,557	(1,274)	283	283	283	283	283	283

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PROGRAM MANAGEMENT, PROPOSED LAW	FY 1988	* ** ** ** **	FY 1989	* ** ** ** **	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
		PRIOR ESTIMATE	CHANGE	CURRENT ESTIMATE					
1)	0	0	0	0	0	0	0	0	0
Less Trust Fund Transfer	0	0	0	0	0	0	0	0	0
B.A. / Outlays	0	0	0	0	0	0	0	0	0
2)	0	0	0	0	0	0	0	0	0
Less Trust Fund Transfer	0	0	0	0	0	0	0	0	0
B.A. / Outlays	0	0	0	0	0	0	0	0	0
3)	0	0	0	0	0	0	0	0	0
Less Trust Fund Transfer	0	0	0	0	0	0	0	0	0
B.A. / Outlays	0	0	0	0	0	0	0	0	0
4)	0	0	0	0	0	0	0	0	0
Less Trust Fund Transfer	0	0	0	0	0	0	0	0	0
B.A. / Outlays	0	0	0	0	0	0	0	0	0
5)	0	0	0	0	0	0	0	0	0
Less Trust Fund Transfer	0	0	0	0	0	0	0	0	0
B.A. / Outlays	0	0	0	0	0	0	0	0	0
TOTAL PROGRAM LEVEL, PROPOSED LAW	0	0	0	0	0	0	0	0	0
TOTAL TRUST FUND TRANSFER, P.L.	0	0	0	0	0	0	0	0	0
TOTAL B.A./OUTLAYS, P.L.	0	0	0	0	0	0	0	0	0
TOTAL PROGRAM LEVEL NET P.L.	1,528,110	1,759,959	12,008	1,771,967	2,078,696	2,401,040	2,757,977	3,113,982	3,525,480
TOTAL TRUST FUND TRANSFER NET P.L.	(1,428,342)	(1,663,156)	(12,008)	(1,675,164)	(1,976,616)	(2,294,537)	(2,646,349)	(3,000,847)	(3,410,910)
TOTAL B.A. NET PROPOSED LAW	99,768	96,803	0	96,803	102,080	106,503	111,628	113,135	114,570
TOTAL OUTLAYS NET PROPOSED LAW	100,803	90,808	9,235	100,043	99,361	103,085	107,348	108,692	109,981

Date last calculated 6/10/88 Time last calculated 8:30 AM	FY 1988	* ** ** ** ** PRIOR ESTIMATE	FY 1989 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
PAYMENTS TO HEALTH CARE TRUST FUNDS									
B.A./OUTLAYS, CURRENT LAW									
1) MILITARY SERVICE CREDITS	0	0	0	0	0	0	0	0	0
2) HI FOR THE UNINSURED	461,000	493,000	0	493,000	377,000	328,000	288,000	248,000	214,000
3) HI FOR UNINSURED FEDERAL ANNUITANTS AND EMPLOYEES	14,000	22,000	0	22,000	35,000	49,000	64,000	77,000	93,000
4) FEDERAL CONTRIBUTION FOR SMI	25,418,000	31,585,000	(293,000)	31,292,000	34,339,000	39,978,000	46,577,000	54,113,000	62,868,000
5) EXPIRED	0	0	0	0	0	0	0	0	0
SUBTOTAL, APPROPRIATION C.L.	25,893,000	32,100,000	(293,000)	31,807,000	34,751,000	40,355,000	46,929,000	54,438,000	63,175,000
SUBTOTAL, OUTLAYS FROM APPR.	25,893,000	32,100,000	(293,000)	31,807,000	34,751,000	40,355,000	46,929,000	54,438,000	63,175,000
6) SECA CREDITS	544,000	541,000	19,000	560,000	370,000	(5,000)	32,000	16,000	16,000
TOTAL B.A., CURRENT LAW	26,437,000	32,641,000	(274,000)	32,367,000	35,121,000	40,350,000	46,961,000	54,454,000	63,191,000
TOTAL OUTLAYS, CURRENT LAW	26,437,000	32,641,000	(274,000)	32,367,000	35,121,000	40,350,000	46,961,000	54,454,000	63,191,000
B.A./OUTLAYS, PROPOSED LAW									
1) HI FOR THE UNINSURED	0	0	0	0	0	(17,000)	(7,000)	(6,000)	(5,000)
2) HI FOR UNINSURED FEDERAL ANNUITANTS AND EMPLOYEES	0	0	0	0	0	(1,000)	(1,000)	(2,000)	(1,000)
3) FEDERAL CONTRIBUTION FOR SMI	0	(205,000)	205,000	0	(663,000)	(1,514,000)	(2,523,000)	(3,809,000)	(6,443,000)
TOTAL APPROPRIATION, P.L.	0	(205,000)	205,000	0	(663,000)	(1,532,000)	(2,531,000)	(3,817,000)	(6,449,000)
5) SECA CREDITS	0	0	0	0	0	0	0	0	0
TOTAL B.A./OUTLAYS, P.L.	0	(205,000)	205,000	0	(663,000)	(1,532,000)	(2,531,000)	(3,817,000)	(6,449,000)
TOTAL APPROPRIATIONS, NET P.L.	25,893,000	31,895,000	(88,000)	31,807,000	34,088,000	38,823,000	44,398,000	50,621,000	56,726,000
TOTAL B.A., NET PROPOSED LAW	26,437,000	32,436,000	(69,000)	32,367,000	34,458,000	38,818,000	44,430,000	50,637,000	56,742,000
TOTAL OUTLAYS, NET PROPOSED LAW	26,437,000	32,436,000	(69,000)	32,367,000	34,458,000	38,818,000	44,430,000	50,637,000	56,742,000

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	FY 1988	* ** ** ** **	FY 1989	* ** ** ** **	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
		PRIOR ESTIMATE	CHANGE	CURRENT ESTIMATE					
TOTAL TRUST FUNDS									
INCOME, CURRENT LAW									
Income w/o Off Receipts	94,093,500	105,086,000	(168,253)	104,917,747	113,652,837	125,134,000	137,197,900	150,617,100	165,678,000
Offsetting Receipts	8,773,000	10,563,000	(86,000)	10,477,000	11,331,000	12,021,000	12,684,000	13,312,000	13,971,000
TOTAL INCOME , CURRENT LAW	102,866,500	115,649,000	(254,253)	115,394,747	124,983,837	137,155,000	149,881,900	163,929,100	179,649,000
INCOME, PROPOSED LAW									
Income w/o Off Receipts	0	1,462,000	(1,462,000)	0	776,000	735,000	49,000	(1,043,000)	(3,462,000)
Offsetting Receipts	0	(87,000)	87,000	0	630,000	1,570,000	2,240,000	3,730,000	5,500,000
TOTAL INCOME , PROPOSED LAW	0	1,375,000	(1,375,000)	0	1,406,000	2,305,000	2,289,000	2,687,000	2,038,000
TOTAL INCOME W/OUT OFF RECEIPTS NET PROPOSED LAW	94,093,500	106,548,000	(1,630,253)	104,917,747	114,428,837	125,869,000	137,246,900	149,574,100	162,216,000
TOTAL OFF. RECEIPTS NET P.L.	8,773,000	10,476,000	1,000	10,477,000	11,961,000	13,591,000	14,924,000	17,042,000	19,471,000
TOTAL INCOME , NET PROPOSED LAW	102,866,500	117,024,000	(1,629,253)	115,394,747	126,389,837	139,460,000	152,170,900	166,616,100	181,687,000
OUTLAYS, CURRENT LAW									
Benefits	86,049,000	93,329,000	947,000	94,276,000	106,020,000	118,671,000	132,518,000	147,210,000	163,616,059
Administration	1,948,030	2,156,649	(57,851)	2,098,798	2,486,959	2,794,302	3,137,701	3,484,786	3,880,880
Peer Review Organizations	189,473	322,030	(516)	321,514	305,883	352,308	380,941	367,549	416,904
TOTAL OUTLAYS, CURRENT LAW	88,186,503	95,807,679	888,633	96,696,312	108,812,842	121,817,610	136,036,642	151,062,335	167,913,843 ERROR
TOTAL OUTLAYS, CURRENT LAW, NET OF OFFSETTING RECEIPTS	79,413,503	85,244,679	974,633	86,219,312	97,481,842	109,796,610	123,352,642	137,750,335	153,942,843
OUTLAYS, PROPOSED LAW									
Benefits	0	(1,317,000)	1,317,000	0	(2,917,000)	(4,708,000)	(5,458,000)	(6,234,000)	(7,200,000)
Administration	0	0	0	0	0	0	0	0	0
TOTAL OUTLAYS, PROPOSED LEG.	0	(1,317,000)	1,317,000	0	(2,917,000)	(4,708,000)	(5,458,000)	(6,234,000)	(7,200,000)
TOTAL OUTLAYS, P.L., NET O.R.	0	(1,230,000)	1,230,000	0	(3,547,000)	(6,278,000)	(7,698,000)	(9,964,000)	(12,700,000)
OUTLAYS, NET PROPOSED LAW									
Benefits	86,049,000	92,012,000	2,264,000	94,276,000	103,103,000	113,963,000	127,060,000	140,976,000	156,416,059
Administration	2,137,503	2,478,679	(58,367)	2,420,312	2,792,842	3,146,610	3,518,642	3,852,335	4,297,784
TOTAL OUTLAYS, NET P.L.	88,186,503	94,490,679	2,205,633	96,696,312	105,895,842	117,109,610	130,578,642	144,828,335	160,713,843
TOTAL OUTLAYS, NET P.L., NET OF OFFSETTING RECEIPTS	79,413,503	84,014,679	2,204,633	86,219,312	93,934,842	103,518,610	115,654,642	127,786,335	141,242,843

10-Jun-88 FY 1990 Department Submission HCFA Division of Budget

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FEDERAL HOSPITAL INSURANCE (HI)									
HI INCOME, CURRENT LAW									
1)INCOME W/OUT OFFSETTING RECEIPTS									
a) FICA	56,369,000	59,751,000	87,000	59,838,000	64,055,000	68,531,000	72,754,000	77,811,000	83,220,000
b) SECA	3,404,000	3,518,000	125,000	3,643,000	4,135,000	4,905,000	5,297,000	5,546,000	5,807,000
c) Refunds	(157,000)	(174,000)	1,000	(173,000)	(194,000)	(211,000)	(229,000)	(240,000)	(252,000)
d) Deposits by States	(52,000)	0	0	0	0	0	0	0	0
e) Fed Employer Contrib (Postal)	332,000	338,000	5,000	343,000	362,000	378,000	398,000	416,000	439,000
f) Fed Employer Contrib	1,474,000	1,526,000	(14,000)	1,512,000	1,584,000	1,648,000	1,716,000	1,796,000	1,880,000
g) General Fund Transfer	1,019,000	1,056,000	19,000	1,075,000	782,000	372,000	384,000	341,000	323,000
h) Interest	5,153,000	6,305,000	(55,000)	6,250,000	7,320,000	8,210,000	8,914,000	9,398,000	9,908,000
i) RRB Transfer	324,000	309,700	0	309,700	297,600	288,100	282,000	277,500	273,000
j) RRB Interest	27,500	29,300	0	29,300	24,500	21,900	18,900	14,600	11,000
k) MSC Transfer DoD	80,000	81,000	4,747	85,747	106,737	91,000	91,000	92,000	93,000
l) Gifts	0	0	0	0	0	0	0	0	0
m) Other	0	0	0	0	0	0	0	0	0
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TOTAL INCOME W/OUT OFFSETTING RECEIPTS	67,973,500	72,740,000	172,747	72,912,747	78,472,837	84,234,000	89,625,900	95,454,100	101,702,000
2)OFFSETTING RECEIPTS									
a) Premiums Collected	47,000	54,000	1,000	55,000	59,000	65,000	69,000	73,000	77,000
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TOTAL OFFSETTING RECEIPTS	47,000	54,000	1,000	55,000	59,000	65,000	69,000	73,000	77,000
TOTAL INCOME, CURRENT LAW	68,020,500	72,794,000	173,747	72,967,747	78,531,837	84,299,000	89,694,900	95,527,100	101,779,000

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	FY 1988	FY 1989			FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
		PRIOR ESTIMATE	CHANGE	CURRENT ESTIMATE					
HI INCOME, PROPOSED LAW									
a) FICA: All State and Local Empl	0	1,615,000	(1,615,000)	0	1,387,000	2,039,000	2,060,000	2,064,000	2,057,000
b) FICA: SSA Proposals.	0	0	0	0	0	0	0	0	0
c) FED EMPL	0	0	0	0	0	0	0	0	0
d) REFUNDS: Inactive Milit. Res.	0	0	0	0	0	0	0	0	0
e) SECA	0	0	0	0	0	0	0	0	0
f) Fed Employer (Postal)	0	0	0	0	0	0	0	0	0
h) General Fund Transfer	0	0	0	0	0	(18,000)	(8,000)	(8,000)	(6,000)
i) Interest	0	45,000	(45,000)	0	45,000	220,000	510,000	700,000	920,000
j)	0	0	0	0	0	0	0	0	0
k)	0	0	0	0	0	0	0	0	0
l)	0	0	0	0	0	0	0	0	0
l)	0	0	0	0	0	0	0	0	0
SUBTOTAL, INCOME W/OUT OFFSETTING RECEIPTS	0	1,660,000	(1,660,000)	0	1,432,000	2,241,000	2,562,000	2,756,000	2,971,000
2)OFFSETTING RECEIPTS									
a) Premiums Collected	0	0	0	0	0	0	0	0	0
SUBTOTAL, OFFSETTING RECEIPTS	0	0	0	0	0	0	0	0	0
TOTAL INCOME, PROPOSED LEGISLATION	0	1,660,000	(1,660,000)	0	1,432,000	2,241,000	2,562,000	2,756,000	2,971,000
TOTAL INCOME W/OUT OFF RECEIPTS NET PROPOSED LAW	67,973,500	74,400,000	(1,487,253)	72,912,747	79,904,837	86,475,000	92,187,900	98,210,100	104,673,000
TOTAL OFF RECEIPTS NET P.L.	47,000	54,000	1,000	55,000	59,000	65,000	69,000	73,000	77,000
TOTAL INCOME NET PROPOSED LAW	68,020,500	74,454,000	(1,486,253)	72,967,747	79,963,837	86,540,000	92,256,900	98,283,100	104,750,000

	FY 1988			FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
END OF YEAR BALANCE									
CURRENT LAW	65,969,915			82,021,433	96,880,145	110,922,374	123,644,583	135,533,187	146,374,480
PROPOSED LAW	65,969,915			82,021,433	100,432,145	119,861,374	138,611,583	157,033,187	174,957,480

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	-------	PRIOR ESTIMATE	CHANGE	CURRENT ESTIMATE	-------	-------	-------	-------	-------
HI OUTLAYS , CURRENT LAW									
1) BENEFITS									
a) Base	54,084,100	57,260,400	1,053,000	58,313,400	65,130,000	71,747,800	78,371,800	85,104,100	92,431,000
b) Payment Safeguard Savings	(2,044,100)	(2,195,400)	0	(2,195,400)	(2,387,000)	(2,465,800)	(2,534,800)	(2,593,100)	(2,652,700)
c) MSP (No Fault)	0	(38,000)	0	(38,000)	(38,000)	(38,000)	(38,000)	(38,000)	(38,000)
d) Direct Med. Ed. Reg.	0	(430,000)	100,000	(330,000)	(400,000)	(480,000)	(440,000)	(530,000)	(638,000)
Subtotal, Benefits Current Law	52,040,000	54,597,000	1,153,000	55,750,000	62,305,000	68,764,000	75,359,000	81,943,000	89,102,300
2) PEER REVIEW ORG's	170,526	257,367	(3,371)	253,996	241,648	278,323	300,943	290,363	329,354
Subtotal Benefit/PRO	52,210,526	54,854,367	1,149,629	56,003,996	62,546,648	69,042,323	75,659,943	82,233,363	89,431,654
3) RESEARCH	7,591	8,228	833	9,061	16,561	30,303	43,693	44,916	45,950
4) ADMINISTRATION									
a) Program Management	558,613	587,571	65,385	652,956	765,998	838,799	918,564	1,005,464	1,104,201
b) SSA	285,583	282,451	(81,711)	200,740	293,934	294,869	298,942	302,094	302,094
c) Other Non-HCFA	54,933	49,476	0	49,476	49,984	50,477	51,549	52,659	53,808
Subtotal, Administration C.L.	899,129	919,498	(16,326)	903,172	1,109,916	1,184,145	1,269,055	1,360,217	1,460,103
Subtotal, Admin/Research	906,720	927,726	(15,493)	912,233	1,126,477	1,214,448	1,312,748	1,405,133	1,506,053
Subtotal, Admin/Research/PRO	1,077,246	1,185,093	(18,864)	1,166,229	1,368,125	1,492,771	1,613,691	1,695,496	1,835,407
TOTAL OUTLAYS, CURRENT LAW	53,117,246	55,782,093	1,134,136	56,916,229	63,673,125	70,256,771	76,972,691	83,638,496	90,937,707
TOTAL OUTLAYS, CURRENT LAW, NET OF OFFSETTING RECEIPTS	53,070,246	55,728,093	1,133,136	56,861,229	63,614,125	70,191,771	76,903,691	83,565,496	90,860,707

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HI OUTLAYS PROPOSED LAW									
1) BENEFITS									
a) Retain Capital at 85%	0	0	0	0	(920,000)	(1,190,000)	(1,300,000)	(1,420,000)	(1,550,000)
b) Misc MSP- HI Split	0	0	0	0	(100,000)	(385,000)	(415,000)	(445,000)	(475,000)
c) PPS Update- Restore Sect. Discretion	0	0	0	0	0	0	0	0	0
d) Reduce Indirect ME to 4.05%	0	(920,000)	920,000	0	(1,030,000)	(1,480,000)	(1,650,000)	(1,800,000)	(1,964,000)
e) MSP- Conform Enforcement Mech	0	(10,000)	10,000	0	(10,000)	(11,000)	(11,000)	(12,000)	(12,000)
f) GME Overhead Reductions	0	(50,000)	50,000	0	(60,000)	(80,000)	(90,000)	(100,000)	(111,000)
Subtotal, Benefits Proposed Law	0	(980,000)	980,000	0	(2,120,000)	(3,146,000)	(3,466,000)	(3,777,000)	(4,112,000)
2) ADMINISTRATION									
a)	0	0	0	0	0	0	0	0	0
Subtotal, Administration P.L.	0	0	0	0	0	0	0	0	0
TOTAL OUTLAYS, PROPOSED LAW	0	(980,000)	980,000	0	(2,120,000)	(3,146,000)	(3,466,000)	(3,777,000)	(4,112,000)
TOTAL OUTLAYS, PROPOSED LAW, NET OF OFFSETTING RECEIPTS	0	(980,000)	980,000	0	(2,120,000)	(3,146,000)	(3,466,000)	(3,777,000)	(4,112,000)
TOTAL OUTLAYS, NET P.L.	53,117,246	54,802,093	2,114,136	56,916,229	61,553,125	67,110,771	73,506,691	79,861,496	86,825,707
TOTAL OUTLAYS, NET P.L. AND OFFSETTING RECEIPTS	53,070,246	54,748,093	2,113,136	56,861,229	61,494,125	67,045,771	73,437,691	79,788,496	86,748,707
TOTAL BENEFITS OUTLAYS, NET P.L.	52,040,000	53,617,000	2,133,000	55,750,000	60,185,000	65,618,000	71,893,000	78,166,000	84,990,300
TOTAL BENEFIT OUTLAYS, NET P.L. AND OFFSETTING RECEIPTS	51,993,000	53,563,000	2,132,000	55,695,000	60,126,000	65,553,000	71,824,000	78,093,000	84,913,300

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	-------	PRIOR ESTIMATE	CHANGE	CURRENT ESTIMATE	-------	-------	-------	-------	-------
FEDERAL SUPPLEMENTARY MEDICAL INSURANCE (SMI)									
SMI INCOME, CURRENT LAW									
1)INCOME W/OUT OFFSETTING RECEIPTS									
a) Federal Contribution	25,418,000	31,585,000	(293,000)	31,292,000	34,339,000	39,978,000	46,577,000	54,113,000	62,868,000
b) Interest	702,000	761,000	(48,000)	713,000	841,000	922,000	995,000	1,050,000	1,108,000
c) Other	0	0	0	0	0	0	0	0	0
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TOTAL INCOME W/OUT OFFSETTING RECEIPTS	26,120,000	32,346,000	(341,000)	32,005,000	35,180,000	40,900,000	47,572,000	55,163,000	63,976,000
2)OFFSETTING RECEIPTS									
a) Premiums Aged	7,944,000	9,582,000	(106,000)	9,476,000	10,236,000	10,848,000	11,437,000	11,992,000	12,574,000
b) Premiums Disabled	782,000	927,000	19,000	946,000	1,036,000	1,108,000	1,178,000	1,247,000	1,320,000
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TOTAL OFFSETTING RECEIPTS	8,726,000	10,509,000	(87,000)	10,422,000	11,272,000	11,956,000	12,615,000	13,239,000	13,894,000
TOTAL INCOME, CURRENT LAW	34,846,000	42,855,000	(428,000)	42,427,000	46,452,000	52,856,000	60,187,000	68,402,000	77,870,000

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		PRIOR ESTIMATE	CHANGE	CURRENT ESTIMATE					
SMI INCOME, PROPOSED LAW									
1)INCOME W/OUT OFFSETTING RECEIPTS									
a) Federal Contribution	0	(205,000)	205,000	0	(663,000)	(1,514,000)	(2,523,000)	(3,809,000)	(6,443,000)
b) Interest	0	7,000	(7,000)	0	7,000	8,000	10,000	10,000	10,000
c) All Other	0	0	0	0	0	0	0	0	0
Subtotal Income w/o receipts	0	(198,000)	198,000	0	(656,000)	(1,506,000)	(2,513,000)	(3,799,000)	(6,433,000)
2)OFFSETTING RECEIPTS									
a) Premiums Aged	0	(80,000)	80,000	0	572,000	1,424,000	2,030,000	3,383,000	4,989,000
b) Premiums Disabled	0	(7,000)	7,000	0	58,000	146,000	210,000	347,000	511,000
SUBTOTAL, OFFSETTING RECEIPTS	0	(87,000)	87,000	0	630,000	1,570,000	2,240,000	3,730,000	5,500,000
TOTAL INCOME, PROPOSED LEGISLATION	0	(285,000)	285,000	0	(26,000)	64,000	(273,000)	(69,000)	(933,000)
TOTAL INCOME W/OUT OFF RECEIPTS NET PROPOSED LAW	26,120,000	32,148,000	(143,000)	32,005,000	34,524,000	39,394,000	45,059,000	51,364,000	57,543,000
TOTAL OFF RECEIPTS NET P.L.	8,726,000	10,422,000	0	10,422,000	11,902,000	13,526,000	14,855,000	16,969,000	19,394,000
TOTAL INCOME NET PROPOSED LAW	34,846,000	42,570,000	(143,000)	42,427,000	46,426,000	52,920,000	59,914,000	68,333,000	76,937,000

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SMI OUTLAYS , CURRENT LAW

	FY 1988	* ** ** ** **	FY 1989	* ** ** ** **	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
		PRIOR ESTIMATE	CHANGE	CURRENT ESTIMATE					
1) BENEFITS									
a) BASE	34,841,387	40,002,913	(205,989)	39,796,924	45,162,929	51,407,809	58,708,640	66,859,329	76,142,000
b) Payment Safeguard Savings	(839,000)	(1,266,000)	0	(1,266,000)	(1,443,500)	(1,496,910)	(1,546,308)	(1,589,604)	(1,626,165)
c) MSP No Fault	0	(12,000)	0	(12,000)	(12,000)	(12,000)	(12,000)	(12,000)	(12,000)
Subtotal, Benefits Current Law	34,002,387	38,724,913	(205,989)	38,518,924	43,707,429	49,898,899	57,150,332	65,257,725	74,503,835
2) ESRD NETWORKS	6,613	7,087	(11)	7,076	7,571	8,101	8,668	9,275	9,924
Subtotal,Benefits/ESRD	34,009,000	38,732,000	(206,000)	38,526,000	43,715,000	49,907,000	57,159,000	65,267,000	74,513,759
3) PEER REVIEW ORG'S	18,947	64,663	2,855	67,518	64,235	73,985	79,998	77,186	87,550
Subtotal,Benefits/ESRD/PRO	34,027,947	38,796,663	(203,145)	38,593,518	43,779,235	49,980,985	57,238,998	65,344,186	74,601,309
4)RESEARCH	7,590	8,228	832	9,060	24,841	45,454	65,539	67,374	68,923
4) ADMINISTRATION									
a) Program Management	812,492	1,001,331	(43,190)	958,141	1,108,644	1,304,884	1,527,753	1,779,318	2,073,011
b) SSA	200,740	200,740	0	200,740	208,595	211,121	213,334	214,702	214,702
c) Other Non-HCFA	20,488	18,624	0	18,624	18,402	18,395	18,327	18,259	18,191
Subtotal, Administration C.L.	1,033,720	1,220,695	(43,190)	1,177,505	1,335,641	1,534,400	1,759,414	2,012,279	2,305,904
Subtotal, Admin/Research	1,041,310	1,228,923	(42,358)	1,186,565	1,360,482	1,579,854	1,824,953	2,079,653	2,374,827
Subtotal, Admin/Research/PRO	1,060,257	1,293,586	(39,503)	1,254,083	1,424,717	1,653,839	1,904,951	2,156,839	2,462,377
TOTAL OUTLAYS, CURRENT LAW	35,069,257	40,025,586	(245,503)	39,780,083	45,139,717	51,560,839	59,063,951	67,423,839	76,976,136
TOTAL OUTLAYS, CURRENT LAW, NET of OFFSETTING RECEIPTS	26,343,257	29,516,586	(158,503)	29,358,083	33,867,717	39,604,839	46,448,951	54,184,839	63,082,136

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SMI OUTLAYS PROPOSED LAW

	FY 1988	* ** ** ** ** PRIOR ESTIMATE	FY 1989 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
1) BENEFITS									
a) Freeze MEI for Non-Primary	0	0	0	0	(200,000)	(550,000)	(750,000)	(1,000,000)	(1,333,000)
b) Clinical Labs-Delay Fee Schd.	0	0	0	0	(100,000)	(120,000)	(150,000)	(170,000)	(210,000)
c) Misc. MSP- SMI Split	0	0	0	0	(40,000)	(145,000)	(155,000)	(165,000)	(180,000)
d) Additional Part B Savings	0	0	0	0	(60,000)	(70,000)	(80,000)	(90,000)	(100,000)
e) DME Rental Cap	0	(80,000)	80,000	0	(80,000)	(130,000)	(160,000)	(190,000)	(226,000)
f) Overpriced Procedures	0	(25,000)	25,000	0	(30,000)	(75,000)	(90,000)	(100,000)	(111,000)
g) Cap Method 2 ESRD Payments	0	(50,000)	50,000	0	(50,000)	(100,000)	(150,000)	(230,000)	(353,000)
h) GME Overhead Reductions	0	(10,000)	10,000	0	(20,000)	(20,000)	(20,000)	(20,000)	(20,000)
i) DME- Oxygen (Additional 5%)	0	(30,000)	30,000	0	(30,000)	(40,000)	(60,000)	(70,000)	(82,000)
j) Secondary Payor- Conform Enforcement Mechanisms	0	(2,000)	2,000	0	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)
k) Enteral Nutrients	0	(25,000)	25,000	0	(30,000)	(40,000)	(60,000)	(70,000)	(82,000)
l) CRNA Supervision- Elim. Dup.	0	(10,000)	10,000	0	(10,000)	(20,000)	(25,000)	(25,000)	(25,000)
m) Reduce Radiology Pmts. 10%	0	(65,000)	65,000	0	(100,000)	(170,000)	(200,000)	(225,000)	(253,000)
n) Reduce Anesthesiology 10%	0	(40,000)	40,000	0	(45,000)	(80,000)	(90,000)	(100,000)	(111,000)
Subtotal, Benefits Proposed Law	0	(337,000)	337,000	0	(797,000)	(1,562,000)	(1,992,000)	(2,457,000)	(3,088,000)
2) ADMINISTRATION									
a)	0	0	0	0	0	0	0	0	0
b)	0	0	0	0	0	0	0	0	0
Subtotal, Administration P.L.	0	0	0	0	0	0	0	0	0
TOTAL OUTLAYS, PROPOSED LAW	0	(337,000)	337,000	0	(797,000)	(1,562,000)	(1,992,000)	(2,457,000)	(3,088,000)
TOTAL OUTLAYS, PROPOSED LAW, NET OF OFFSETTING RECEIPTS	0	(250,000)	250,000	0	(1,427,000)	(3,132,000)	(4,232,000)	(6,187,000)	(8,583,000)
TOTAL BENEFIT OUTLAYS, NET P.L.	34,027,947	38,459,663	133,855	38,593,518	42,982,235	48,418,985	55,246,998	62,887,186	71,513,309
TOTAL ADMINISTRATION, NET P.L.	1,041,310	1,228,923	(42,358)	1,186,565	1,360,482	1,579,854	1,824,953	2,079,653	2,374,827
TOTAL OUTLAYS, NET P.L.	35,069,257	39,688,586	91,497	39,780,083	44,342,717	49,998,839	57,071,951	64,966,839	73,888,136
TOTAL OUTLAYS, NET P.L. AND OFFSETTING RECEIPTS	26,343,257	29,266,586	91,497	29,358,083	32,440,717	36,472,839	42,216,951	47,997,839	54,494,136
TOTAL BENEFIT OUTLAYS, NET P.L. AND OFFSETTING RECEIPTS	25,301,947	28,037,663	133,855	28,171,518	31,080,235	34,892,985	40,391,998	45,918,186	52,119,309
END OF YEAR BALANCE									
CURRENT LAW	6,090,623			8,737,540	10,049,823	11,344,984	12,468,033	13,446,194	14,340,058
PROPOSED LAW	6,090,623			8,737,540	10,820,823	13,741,984	16,584,033	19,950,194	22,999,058

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HCFA PROGRAM MANAGEMENT - OUTLAYS									
o CURRENT SERVICES	100,803	90,808	9,235	100,043	97,376	98,770	99,995	101,026	102,081
o CURRENT LAW	100,803	90,808	9,235	100,043	99,361	103,085	107,348	108,692	109,981
DIFFERENCE	0	0	0	0	(1,985)	(4,315)	(7,353)	(7,666)	(7,900)
HOSPITAL INSURANCE									
HCFA PROGRAM MANAGEMENT									
o CURRENT SERVICES	565,993	519,663	381,983	901,646	685,149	705,228	722,846	737,695	737,696
o CURRENT LAW	566,204	595,799	66,218	662,017	782,559	869,102	962,257	1,050,380	1,150,151
DIFFERENCE	(211)	(76,136)	315,765	239,629	(97,410)	(163,874)	(239,411)	(312,685)	(412,455)
SUPPLEMENTARY MEDICAL INSURANCE									
HCFA PROGRAM MANAGEMENT									
o CURRENT SERVICES	820,293	816,617	(81,352)	735,265	998,987	1,030,202	1,057,564	1,080,666	1,080,666
o CURRENT LAW	820,082	1,009,559	(42,358)	967,201	1,133,485	1,350,338	1,593,292	1,846,692	2,141,934
DIFFERENCE	211	(192,942)	(38,994)	(231,936)	(134,498)	(320,136)	(535,728)	(766,026)	(1,061,268)

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HCFA Division of Budget

Date last calculated 6/10/88 Time last calculated 8:30 AM	FY 1988	* ** ** ** ** PRIOR ESTIMATE	FY 1989 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
CURRENT SERVICES									
TOTAL BUDGET AUTHORITY									
1) MEDICAID	30,811,859	33,145,839	618,208	33,764,047	36,980,442	39,786,919	43,631,397	47,576,499	51,701,774
2) PROGRAM MANAGEMENT	98,211	95,246	1,274	96,520	98,104	99,596	100,906	102,008	103,137
3) HOSPITAL INSURANCE	68,020,500	72,794,000	175,747	72,969,747	78,576,837	84,361,000	89,769,900	95,596,100	101,841,000
4) SUPPLEMENTARY MEDICAL INSURANCE	34,846,000	42,737,000	(428,000)	42,309,000	46,237,000	52,612,000	59,943,000	68,093,000	77,480,000
TOTAL BUDGET AUTHORITY	133,776,570	148,772,085	367,229	149,139,314	161,892,383	176,859,515	193,445,203	211,367,607	231,125,911
TOTAL OUTLAYS									
1) MEDICAID	30,818,559	33,145,839	618,208	33,764,047	36,980,442	39,786,919	43,631,397	47,576,499	51,701,774
2) PROGRAM MANAGEMENT	100,803	90,808	9,235	100,043	97,376	98,770	99,995	101,026	102,081
3) HOSPITAL INSURANCE	53,117,035	55,712,520	1,531,613	57,244,133	63,883,568	70,448,306	76,790,317	83,739,201	90,885,742
4) SUPPLEMENTARY MEDICAL INSURANCE	35,071,890	39,835,182	(284,498)	39,550,684	45,104,376	51,330,610	58,539,592	66,765,244	76,008,266
TOTAL OUTLAYS	119,108,287	128,784,349	1,874,558	130,658,907	146,065,762	161,664,605	179,061,301	198,181,970	218,697,863

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CURRENT SERVICES									
GRANTS TO STATES FOR MEDICAID									
1) MEDICAL ASSISTANCE PAYMENTS									
a) State Estimates (5/88)	29,254,594	31,683,706	546,401	32,230,107	35,027,483	37,514,246	41,003,486	44,707,304	48,814,000
Adjustments	(146,273)	(200,419)	(2,732)	(203,151)	(175,137)	0	0	0	0
MEDICAL ASSISTANCE, ADJUSTED	29,108,321	31,483,287	543,669	32,026,956	34,852,346	37,514,246	41,003,486	44,707,304	48,814,000
b) Prior Year Claims	6,700	0	0	0	0	0	0	0	0
c) MQC Dis includes Withholding	0	(3,800)	0	(3,800)	(19,600)	(189,200)	(85,200)	(40,000)	(40,000)
d) Financial Adjustments	107,021	0	0	0	0	0	0	0	0
e) Medicaid Initiatives	(72,700)	(308,000)	65,000	(243,000)	(250,000)	(277,000)	(306,000)	(337,000)	(360,000)
f) Immigration Reform	0	0	0	0	0	0	0	0	0
g) OBRA '87 Impact - See detail	71,000	310,000	(14,000)	296,000	625,000	877,000	1,106,000	1,292,000	1,292,000
SUBTOTAL, MEDICAL ASSISTANCE OUT.	29,220,342	31,481,487	594,669	32,076,156	35,207,746	37,925,046	41,718,286	45,622,304	49,706,000
SUBTOTAL,OBL.WHERE DIFF.FROM OUT.									
2) STATE AND LOCAL ADMINISTRATION									
a) State Estimates (5/88)	1,525,131	1,580,840	37,669	1,618,509	1,686,353	1,745,400	1,797,800	1,840,900	1,885,100
b) Financial & Other Adjustments	(21,627)	(7,904)	(189)	(8,093)	(8,432)	(8,727)	(8,989)	(9,205)	(9,426)
c) Immigration Reform	0	0	0	0	0	0	0	0	0
d) Cost Allocation Savings	0	(11,000)	0	(11,000)	(11,000)	(9,000)	(9,000)	(9,000)	(9,000)
SUBTOTAL, S&L ADMINISTRATION	1,503,504	1,561,936	19,880	1,581,816	1,648,621	1,708,773	1,760,311	1,802,695	1,846,174
3) STATE CERTIFICATION									
a) State Estimates (5/88)	49,260	51,711	1,159	52,870	56,570	58,500	60,300	61,700	63,200
b) OBRA '87 Impact	0	3,000	2,500	5,500	19,800	45,200	41,600	37,700	33,000
SUBTOTAL, STATE CERTIFICATION	49,260	54,711	3,659	58,370	76,370	103,700	101,900	99,400	96,200
4) FRAUD CONTROL UNITS									
a) State Estimates (5/88)	45,453	47,705	0	47,705	47,705	49,400	50,900	52,100	53,400
SUBTOTAL, FRAUD CONTROL UNITS	45,453	47,705	0	47,705	47,705	49,400	50,900	52,100	53,400
SUBTOTAL, ALL ADMIN (2-4). OUT.	1,598,217	1,664,352	23,539	1,687,891	1,772,696	1,861,873	1,913,111	1,954,195	1,995,774
SUBTOTAL,OBL.WHERE DIFF.FROM OUT.									
TOTAL OBLIGATIONS/OUTLAYS C.L.	30,818,559	33,145,839	762,958	33,764,047	36,980,442	39,786,919	43,631,397	47,576,499	51,701,774
TOTAL OBL.WHERE DIFF.FROM OUT.									
UNOBLIGATED BALANCE									
o BOY - Regular	0	0	0	0	0	0	0	0	0
o BOY - Prior Year Claims	(6,700)	0	0	0	0	0	0	0	0
o EOY - Expired Accts Returned	0	0	0	0	0	0	0	0	0
o EOY - Prior Year Claims	0	0	0	0	0	0	0	0	0
APPROPRIATION/ BA	30,811,859	33,145,839	618,208	33,764,047	36,980,442	39,786,919	43,631,397	47,576,499	51,701,774
APPROPRIATION WHERE DIF. FROM BA									
INDEFINITE APPRO (NO-ADD)	765,859	0	0	0	0	0	0	0	0
o Advanced Appropriation	7,100,000	8,000,000	0	8,000,000	9,200,000	9,900,000	10,800,000	11,800,000	12,800,000
o Remaining Appropriation	22,946,000	25,145,839	618,208	25,764,047	27,780,442	29,886,919	32,831,397	35,776,499	38,901,774

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CURRENT SERVICES
GRANTS TO STATES FOR MEDICAID

	FY 1988	* ** ** ** **	FY 1989	* ** ** ** **	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
		PRIOR ESTIMATE	CHANGE	CURRENT ESTIMATE					
MEDICAID INITIATIVES - DETAIL									
1) Second Surgical Opinion Prog	0	(15,000)	0	(15,000)	(30,000)	(30,000)	(30,000)	(30,000)	(30,000)
2) Prescript Drug Reform(BERC356F)	0	(60,000)	60,000	0	0	0	0	0	0
3) Medicaid Fin. Mgt. Reviews	(62,700)	(193,000)	0	(193,000)	(170,000)	(187,000)	(206,000)	(227,000)	(250,000)
5) Pymts to Instit (BERC514F)	(10,000)	(35,000)	0	(35,000)	(50,000)	(60,000)	(70,000)	(80,000)	(80,000)
6) LTC Cond (BERC396P)-in OBRA #2	0	0	0	0	0	0	0	0	0
7) Med Need Inc Level (BERC179P)	0	0	0	0	0	0	0	0	0
8) Limit Donations (BQC70P)	0	0	0	0	0	0	0	0	0
9) MMIS Funding Restrict (BQC59P)	0	0	0	0	0	0	0	0	0
10) Survey and Cert. Disallowances	0	(5,000)	5,000	0	0	0	0	0	0
11) State Tax Disallowances	0	0	0	0	0	0	0	0	0
12) Liens/Recoveries	0	0	0	0	0	0	0	0	0
13) Ambulatory Surgery	0	0	0	0	0	0	0	0	0
14) End FFP for Non Med Svc(ICF/MR	0	0	0	0	0	0	0	0	0
15) Pread Test/Same Day Surg	0	0	0	0	0	0	0	0	0
Total Initiatives	(72,700)	(308,000)	65,000	(243,000)	(250,000)	(277,000)	(306,000)	(337,000)	(360,000)

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PROGRAM MANAGEMENT - CURRENT SERVICES									
PEER REVIEW ORGANIZATIONS: OBLIG	377,438	318,750	311,670	630,420	655,006	677,931	698,269	715,027	732,188
ESRD NETWORKS: OBLIG\OUTLAYS	6,613	7,087	(11)	7,076	7,352	7,609	7,837	8,025	8,218
BUDGET AUTHORITY									
1) RESEARCH									
a) Program Level	26,807	32,000	0	32,000	33,184	34,279	35,239	36,049	36,878
b) Less Trust Fund Transfer	(17,233)	(20,571)	0	(20,571)	(21,332)	(22,036)	(22,653)	(23,174)	(23,707)
RESEARCH B.A. - BPS	9,574	11,429	0	11,429	11,852	12,243	12,586	12,875	13,171
2) MEDICARE CONTRACTORS									
2A) Claims Processing									
a) Program Level	826,617	922,500	9,500	932,000	966,484	998,378	1,026,333	1,049,939	1,074,088
b) Less Trust Fund Transfer	(826,617)	(922,500)	(9,500)	(932,000)	(966,484)	(998,378)	(1,026,333)	(1,049,939)	(1,074,088)
Claims Processing B.A.	0	0	0	0	0	0	0	0	0
2B) Payment Safeguards									
a) Program Level	300,100	403,100	5,600	408,700	423,822	437,808	450,067	460,419	471,009
b) Less Trust Fund Transfer	(300,100)	(403,100)	(5,600)	(408,700)	(423,822)	(437,808)	(450,067)	(460,419)	(471,009)
Payment Safeguards B.A.	0	0	0	0	0	0	0	0	0
2C) Productivity Investments									
a) Program Level	54,900	65,400	(15,100)	50,300	52,161	53,882	55,391	56,665	57,968
b) Less Trust Fund Transfer	(54,900)	(65,400)	15,100	(50,300)	(52,161)	(53,882)	(55,391)	(56,665)	(57,968)
Productivity Investments B.A.	0	0	0	0	0	0	0	0	0
2D) Contingency Fund (non-add)	0	0	0	0	0	0	0	0	0
2E) NOU trans fm SSA (non-add)	2,100	0	0	0	0	0	0	0	0
2F) COBRA FUNDS (non-add)	100,527	0	0	0	0	0	0	0	0
a) Total CONTRACTOR Program Level	1,181,617	1,391,000	0	1,391,000	1,442,467	1,490,068	1,531,791	1,567,023	1,603,065
b) Less Total Trust Fund Transfer	(1,181,617)	(1,391,000)	0	(1,391,000)	(1,442,467)	(1,490,068)	(1,531,791)	(1,567,023)	(1,603,065)
TOTAL CONTRACTOR B.A.	0	0	0	0	0	0	0	0	0
3) STATE CERTIFICATION									
a) Program Level	65,859	65,859	0	65,859	68,428	70,823	72,948	74,699	76,492
b) Less Trust Fund Transfer	(57,922)	(62,235)	0	(62,235)	(64,663)	(66,926)	(68,934)	(70,589)	(72,283)
STATE CERTIFICATION B.A.	7,937	3,624	0	3,624	3,765	3,897	4,014	4,110	4,209
SUBTOTAL: SCert\Admin - BPS	88,637			85,091	86,252	87,353	88,320	89,133	89,966

Date last calculated 6/10/88 Time last calculated 8:30 AM	FY 1988	* ** ** ** ** PRIOR ESTIMATE	FY 1989 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
4) ADMINISTRATIVE COSTS									
a) Pay	174,962	182,249	2,708	184,957	184,957	184,957	184,957	184,957	184,957
b) Non-pay	78,865	88,851	9,300	98,151	101,684	105,040	107,981	110,465	113,006
c) Program Level (a+b)	253,827	271,100	12,008	283,108	286,641	289,997	292,938	295,422	297,963
d) Less Trust Fund Transfer	(171,570)	(189,350)	(12,008)	(201,358)	(203,871)	(206,258)	(208,349)	(210,116)	(211,923)
e) User Fee	(1,557)	(1,557)	1,274	(283)	(283)	(283)	(283)	(283)	(283)
ADMINISTRATIVE COSTS B.A.	80,700	80,193	1,274	81,467	82,487	83,456	84,306	85,023	85,757
5) CONTINGENCY FUNDS									
5A) MEDICARE CONTRACTORS									
a) Program Level	0	0	0	0	0	0	0	0	0
b) Less Trust Fund Transfer	0	0	0	0	0	0	0	0	0
Medicare Contractors	0	0	0	0	0	0	0	0	0
5B) PROGRAM MANAGEMENT									
a) Program Level	47,870	112,400	47,600	160,000	165,920	171,395	176,194	180,246	184,392
b) Less Trust Fund Transfer	(47,870)	(112,400)	(47,600)	(160,000)	(165,920)	(171,395)	(176,194)	(180,246)	(184,392)
Program Management	0	0	0	0	0	0	0	0	0
a) Total CONTINGENCY Program Level	47,870	112,400	47,600	160,000	165,920	171,395	176,194	180,246	184,392
b) Less Total Trust Fund Transfer	(47,870)	(112,400)	(47,600)	(160,000)	(165,920)	(171,395)	(176,194)	(180,246)	(184,392)
TOTAL CONTINGENCY B.A.	0	0	0	0	0	0	0	0	0
TOTAL PROG LEVEL	1,528,110	1,872,359	59,608	1,931,967	1,996,640	2,056,562	2,109,110	2,153,439	2,198,790
TOTAL TRUST FUND TRANSFER	(1,476,212)	(1,775,556)	(59,608)	(1,835,164)	(1,898,253)	(1,956,683)	(2,007,921)	(2,051,148)	(2,095,370)
TOTAL PROGRAM MANAGEMENT B.A.	98,211	95,246	1,274	96,520	98,104	99,596	100,906	102,008	103,137
ADJUSTMENTS : TRAVEL, ETC.	(330)	0	0	0	0	0	0	0	0
TOTAL OBLIGATIONS WHERE DIF FROM BA	97,881								
1)ADJ									
2) RESEARCH - BPS	12,430	9,813	3,330	13,143	9,482	9,794	10,069	10,300	10,537
3) STATE CERTIFICATION	4,445	3,502	(1,328)	2,174	2,108	2,182	2,248	2,302	2,357
4) ADMINISTRATIVE COSTS	83,928	77,493	7,233	84,726	85,786	86,794	87,678	88,424	89,187
BPS SUBTOTAL:ADMIN\SCERT	88,373			86,900	87,894	88,976	89,926	90,726	91,544
TOTAL PROGRAM MANAGEMENT OUTLAYS	100,803	90,808	9,235	100,043	97,376	98,770	99,995	101,026	102,081
PROGRAM MANAGEMENT USER FEE OUTLAYS	1,557	1,557	(1,274)	283	283	283	283	283	283

Date last calculated 6/10/88 Time last calculated 8:30 AM	FY 1988	* ** ** ** **	FY 1989	* ** ** ** **	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
	-------	PRIOR ESTIMATE	CHANGE	CURRENT ESTIMATE	-------	-------	-------	-------	-------
PAYMENTS TO HEALTH CARE TRUST FUNDS									
B.A./OUTLAYS, CURRENT SERVICES									
1) MILITARY SERVICE CREDITS	0	0	0	0	0	0	0	0	0
2) HI FOR THE UNINSURED	461,000	493,000	0	493,000	377,000	328,000	288,000	248,000	214,000
3) HI FOR UNINSURED FEDERAL			0						
ANNUITANTS AND EMPLOYEES	14,000	22,000	0	22,000	35,000	49,000	64,000	77,000	93,000
4) FEDERAL CONTRIBUTION FOR SMI	25,418,000	31,492,000	(292,000)	31,200,000	34,160,000	39,802,000	46,415,000	53,886,000	62,560,000
5) EXPIRED									
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SUBTOTAL, APPROPRIATION C.S.	25,893,000	32,007,000	(292,000)	31,715,000	34,572,000	40,179,000	46,767,000	54,211,000	62,867,000
6) SECA CREDITS	544,000	541,000	19,000	560,000	370,000	(5,000)	32,000	16,000	16,000
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TOTAL B.A., CURRENT SERVICES	26,437,000	32,548,000	(273,000)	32,275,000	34,942,000	40,174,000	46,799,000	54,227,000	62,883,000
6) MSC QUINQ. ADJUSTMENT									
TOTAL OUTLAYS, CURRENT SERVICES	26,437,000	32,548,000	(273,000)	32,275,000	34,942,000	40,174,000	46,799,000	54,227,000	62,883,000

Date last calculated 6/10/88
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FEDERAL HOSPITAL INSURANCE (HI)

HI INCOME, CURRENT SERVICES

	FY 1988	* ** ** ** **	FY 1989	* ** ** ** **	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
	-------	PRIOR ESTIMATE	CHANGE	CURRENT ESTIMATE	-------	-------	-------	-------	-------
1)INCOME W/OUT OFFSETTING RECEIPTS									
a) FICA *	56,369,000	59,751,000	87,000	59,838,000	64,074,000	68,556,000	72,781,000	77,832,000	83,234,000
b) SECA	3,404,000	3,518,000	125,000	3,643,000	4,135,000	4,905,000	5,297,000	5,546,000	5,807,000
c) Refunds	(157,000)	(174,000)	1,000	(173,000)	(194,000)	(211,000)	(229,000)	(240,000)	(252,000)
d) Deposits by States	(52,000)	0	0	0	0	0	0	0	0
e) Fed Employer Contrib (Postal)	332,000	338,000	5,000	343,000	362,000	378,000	398,000	418,000	439,000
f) Fed Employer Contrib *	1,474,000	1,526,000	(14,000)	1,512,000	1,603,000	1,673,000	1,745,000	1,819,000	1,896,000
g) General Fund Transfer	1,019,000	1,056,000	19,000	1,075,000	782,000	372,000	384,000	341,000	323,000
h) Interest	5,153,000	6,305,000	(53,000)	6,252,000	7,327,000	8,222,000	8,933,000	9,423,000	9,940,000
i) RRB Transfer	324,000	309,700	0	309,700	297,600	288,100	282,000	277,500	273,000
j) RRB Interest	27,500	29,300	0	29,300	24,500	21,900	18,900	14,600	11,000
k) MSC Transfer from DOD	80,000	81,000	4,747	85,747	106,737	91,000	91,000	92,000	93,000
l) Gifts	0	0	0	0	0	0	0	0	0
m) Other	0	0	0	0	0	0	0	0	0
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TOTAL INCOME W/OUT OFFSETTING RECEIPTS	67,973,500	72,740,000	174,747	72,914,747	78,517,837	84,296,000	89,700,900	95,523,100	101,764,000
2)OFFSETTING RECEIPTS									
a) Premiums Collected	47,000	54,000	1,000	55,000	59,000	65,000	69,000	73,000	77,000
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TOTAL OFFSETTING RECEIPTS	47,000	54,000	1,000	55,000	59,000	65,000	69,000	73,000	77,000
TOTAL INCOME, CURRENT SERVICES	68,020,500	72,794,000	175,747	72,969,747	78,576,837	84,361,000	89,769,900	95,596,100	101,841,000

Date last calculated 6/10/88 Time last calculated 8:30 AM	FY 1988	* ** ** ** ** PRIOR ESTIMATE	FY 1989 CHANGE	* ** ** ** ** CURRENT ESTIMATE	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
HI OUTLAYS , CURRENT SERVICES									
1) BENEFITS									
a) Base	54,084,100	57,260,400	1,053,000	58,313,400	65,130,000	71,747,800	78,371,800	85,104,100	92,431,000
b) Payment Safeguard Savings	(2,044,100)	(2,195,400)	0	(2,195,400)	(2,387,000)	(2,465,800)	(2,534,800)	(2,593,100)	(2,652,700)
c) MSP (No Fault)	0	(38,000)	0	(38,000)	(38,000)	(38,000)	(38,000)	(38,000)	(38,000)
d) Direct Med. Ed. Reg.	0	(430,000)	100,000	(330,000)	(400,000)	(480,000)	(440,000)	(530,000)	(638,000)
Subtotal, Benefits Current Service	52,040,000	54,597,000	1,153,000	55,750,000	62,305,000	68,764,000	75,359,000	81,943,000	89,102,300
2) PEER REVIEW ORG's	170,526	257,367	(3,371)	253,996	621,981	621,255	345,322	690,837	676,183
Subtotal Benefit/PRO	52,210,526	54,854,367	1,149,629	56,003,996	62,926,981	69,385,255	75,704,322	82,633,837	89,778,483
3) RESEARCH	7,591	7,031	2,030	9,061	7,517	7,764	7,982	8,166	8,166
4) ADMINISTRATION									
a) Program Management	558,402	512,632	379,953	892,585	677,632	697,464	714,864	729,529	729,530
b) SSA	285,583	282,451	0	282,451	213,334	297,691	300,984	303,764	303,764
c) Other Non-HCFA	54,933	56,039	1	56,040	58,104	60,132	62,165	63,905	65,799
Subtotal, Administration C.S.	898,918	851,122	379,954	1,231,076	949,070	1,055,287	1,078,013	1,097,198	1,099,093
Subtotal, Admin/Research	906,509	858,153	381,984	1,240,137	956,587	1,063,051	1,085,995	1,105,364	1,107,259
Subtotal, Admin/Research/PRO	1,077,035	1,115,520	378,613	1,494,133	1,578,568	1,684,306	1,431,317	1,796,201	1,783,442
TOTAL OUTLAYS, CURRENT SERVICES	53,117,035	55,712,520	1,531,613	57,244,133	63,883,568	70,448,306	76,790,317	83,739,201	90,885,742
TOTAL OUTLAYS, CUR. SERV., NET OF OFFSETTING RECEIPTS	53,070,035	55,658,520	1,530,613	57,189,133	63,824,568	70,383,306	76,721,317	83,666,201	90,808,742

Date last calculated 6/10/88 Time last calculated 8:30 AM	FY 1988	* ** ** ** **	FY 1989	* ** ** ** **	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
		PRIOR ESTIMATE	CHANGE	CURRENT ESTIMATE					
FEDERAL SUPPLEMENTARY MEDICAL INSURANCE (SMI)									
SMI INCOME, CURRENT SERVICES									
1)INCOME W/OUT OFFSETTING RECEIPTS									
a) Federal Contribution	25,418,000	31,492,000	(292,000)	31,200,000	34,160,000	39,802,000	46,415,000	53,886,000	62,560,000
b) Interest	702,000	765,000	(49,000)	716,000	844,000	924,000	996,000	1,051,000	1,109,000
c) Other/Expired	0	0	0	0	0	0	0	0	0
d) Interest on Reimb - SSA	0	0	0	0	0	0	0	0	0
TOTAL INCOME W/OUT OFFSETTING RECEIPTS	26,120,000	32,257,000	(341,000)	31,916,000	35,004,000	40,726,000	47,411,000	54,937,000	63,669,000
2)OFFSETTING RECEIPTS									
a) Premiums Aged	7,944,000	9,555,000	(106,000)	9,449,000	10,200,000	10,784,000	11,362,000	11,917,000	12,499,000
b) Premiums Disabled	782,000	925,000	19,000	944,000	1,033,000	1,102,000	1,170,000	1,239,000	1,312,000
TOTAL OFFSETTING RECEIPTS	8,726,000	10,480,000	(87,000)	10,393,000	11,233,000	11,886,000	12,532,000	13,156,000	13,811,000
TOTAL INCOME, CURRENT SERVICES	34,846,000	42,737,000	(428,000)	42,309,000	46,237,000	52,612,000	59,943,000	68,093,000	77,480,000

Date last calculated 6/10/88 Time last calculated 8:30 AM	FY 1988	* ** ** ** **	FY 1989	* ** ** ** **	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
		PRIOR ESTIMATE	CHANGE	CURRENT ESTIMATE					
SMI OUTLAYS , CURRENT SERVICES									
1) BENEFITS									
a) BASE	34,841,387	40,002,913	(205,989)	39,796,924	45,163,148	51,408,301	58,709,471	66,860,579	76,143,000
b) Payment Safeguard Savings	(839,000)	(1,266,000)	0	(1,266,000)	(1,443,500)	(1,496,910)	(1,546,308)	(1,589,604)	(1,626,165)
c) MSP No Fault	0	(12,000)	0	(12,000)	(12,000)	(12,000)	(12,000)	(12,000)	(12,000)
Subtotal, Benefits Current Service	34,002,387	38,724,913	(205,989)	38,518,924	43,707,648	49,899,391	57,151,163	65,258,975	74,504,835
2) ESRD NETWORKS	6,613	7,087	(11)	7,076	7,352	7,609	7,837	8,025	8,218
Subtotal,Benefits +ESRD	34,009,000	38,732,000	(206,000)	38,526,000	43,715,000	49,907,000	57,159,000	65,267,000	74,513,053
3) PEER REVIEW ORG's	18,947	64,663	2,855	67,518	165,336	165,145	91,794	183,641	179,745
Subtotal,Benefits +ESRD +PRO	34,027,947	38,796,663	(203,145)	38,593,518	43,880,336	50,072,145	57,250,794	65,450,641	74,692,798
4) RESEARCH	7,590	7,031	2,029	9,060	11,275	11,647	11,973	12,248	12,248
5) ADMINISTRATION									
a) Program Management	812,703	809,586	(83,381)	726,205	987,712	1,018,555	1,045,591	1,068,418	1,068,418
b) SSA	203,162	200,740	0	200,740	208,595	211,121	213,334	215,204	215,204
c) Other Non-HCFA	20,488	21,162	(1)	21,161	16,458	17,142	17,900	18,733	19,598
Subtotal, Administration C.S.	1,036,353	1,031,488	(83,382)	948,106	1,212,765	1,246,818	1,276,825	1,302,355	1,303,220
Subtotal, Admin/Research	1,043,943	1,038,519	(81,353)	957,166	1,224,040	1,258,465	1,288,798	1,314,603	1,315,468
TOTAL OUTLAYS, CURRENT SERVICES	35,071,890	39,835,182	(284,498)	39,550,684	45,104,376	51,330,610	58,539,592	66,765,244	76,008,266
TOTAL OUTLAYS, CURRENT SERVICES, NET OF OFFSETTING RECEIPTS	26,345,890	29,355,182	(197,498)	29,157,684	33,871,376	39,444,610	46,007,592	53,609,244	62,197,266

OBLIGATIONS CURRENT LAW	FY 1988 HI	FY 1988 SMI	FY 1988 TOTAL	FY 1989 HI	FY 1989 SMI	FY 1989 TOTAL	FY 1990 HI	FY 1990 SMI	FY 1990 TOTAL
PEER REVIEW ORGANIZATIONS	339,694	37,744	377,438	498,032	132,388	630,420	201,038	53,440	254,478
1)RESEARCH	8,617	8,616	17,233	10,286	10,285	20,571	18,800	28,200	47,000
ADMINISTRATIVE ACTIVITIES									
1)PSRO									
2)CLAIMS PROCESSING	196,983	629,634	826,617	228,400	703,600	932,000	252,900	829,100	1,082,000
3)PAYMENT SAFEGUARDS	203,600	96,500	300,100	247,500	161,200	408,700	284,500	167,500	452,000
4)PRODUCTIVITY INVESTMENTS	19,800	35,100	54,900	18,600	31,700	50,300	35,100	42,400	77,500
5)STATE CERTIFICATION	51,782	6,140	57,922	55,638	6,597	62,235	82,096	10,459	92,555
6)ADMINISTRATIVE COSTS	102,623	68,947	171,570	120,440	80,918	201,358	134,917	90,644	225,561
7)CONTINGENCY FUNDS/REIMB	(212)	(496)	(708)	0	0	0	0	0	0
TOTAL, ADMIN ACTIVITIES	574,576	835,825	1,410,401	670,578	984,015	1,654,593	789,513	1,140,103	1,929,616
TOTAL, RESEARCH/ADMIN	583,193	844,441	1,427,634	680,864	994,300	1,675,164	808,313	1,168,303	1,976,616
SOCIAL SECURITY ADMINISTRATION	279,901	203,162	483,063	285,256	200,740	485,996	293,934	208,595	502,529
OTHER NON-HCFA ADMINISTRATION									
1)TREASURY	29,246	1,190	30,436	29,600	1,507	31,107	30,108	1,292	31,400
2)RAILROAD RETIREMENT BOARD	0	1,500	1,500	0	1,978	1,978	0	2,314	2,314
3)DEPARTMENT MANGEMENT	5,939	4,589	10,528	1,064	1,939	3,003	1,064	1,596	2,660
4)CIVIL RIGHTS	3,901	0	3,901	3,901	0	3,901	3,901	0	3,901
5)INSPECTOR GENERAL	10,400	10,000	20,400	10,400	10,000	20,400	10,400	10,000	20,400
6)OPM	0	85	85	0	85	85	0	85	85
7)PUBLIC HEALTH SERVICE	782	138	920	782	138	920	782	138	920
8)PROSPECTIVE PAYMENT COMMISSION	4,665	0	4,665	3,729	0	3,729	3,729	0	3,729
9)PHYSICIAN PAYMENT REVIEW COMM	0	2,986	2,986	0	2,977	2,977	0	2,977	2,977
SUBTOTAL, OTHER NON-HCFA ADMIN.	54,933	20,488	75,421	49,476	18,624	68,100	49,984	18,402	68,386
TOTAL NON-HCFA ADMINISTRATION	334,834	223,650	558,484	334,732	219,364	554,096	343,918	226,997	570,915
TOTAL OBLIGATIONS CURRENT LAW	918,027	1,068,091	1,986,118	1,015,596	1,213,664	2,229,260	1,152,231	1,395,300	2,547,531

	FY 1991			FY 1992			FY 1993			FY 1994		
OBLIGATIONS CURRENT LAW	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL
PEER REVIEW ORGANIZATIONS	239,934	63,780	303,714	480,739	127,792	608,531	237,419	63,112	300,531	281,740	74,893	356,633
1)RESEARCH	34,400	51,600	86,000	49,600	74,400	124,000	50,989	76,483	127,472	52,162	78,242	130,404
ADMINISTRATIVE ACTIVITIES												
1)PSRO												
2)CLAIMS PROCESSING	312,179	1,023,439	1,335,618	380,147	1,246,261	1,626,408	457,548	1,500,010	1,957,558	548,521	1,798,253	2,346,774
3)PAYMENT SAFEGUARDS	295,027	173,697	468,724	304,763	179,429	484,192	313,296	184,453	497,749	320,501	188,696	509,197
4)PRODUCTIVITY INVESTMENTS	36,259	43,799	80,058	37,274	45,026	82,300	38,131	46,062	84,193	39,008	47,121	86,129
5)STATE CERTIFICATION	84,969	10,825	95,794	87,519	11,149	98,668	89,619	11,417	101,036	91,770	11,691	103,461
6)ADMINISTRATIVE COSTS	136,581	91,762	228,343	138,039	92,742	230,781	139,270	93,569	232,839	140,530	94,415	234,945
7)CONTINGENCY FUNDS/REIMB	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, ADMIN ACTIVITIES	865,015	1,343,522	2,208,537	947,742	1,574,607	2,522,349	1,037,864	1,835,511	2,873,375	1,140,330	2,140,176	3,280,506
TOTAL, RESEARCH/ADMIN	899,415	1,395,122	2,294,537	997,342	1,649,007	2,646,349	1,088,853	1,911,994	3,000,847	1,192,492	2,218,418	3,410,910
SOCIAL SECURITY ADMINISTRATION	294,869	211,121	505,990	298,943	213,334	512,277	298,943	215,204	514,147	298,943	215,204	514,147
OTHER NON-HCFA ADMINISTRATION												
1)TREASURY	30,601	1,296	31,897	31,673	1,233	32,906	32,783	1,173	33,956	33,932	1,116	35,048
2)RAILROAD RETIREMENT BOARD	0	1,978	1,978	0	1,978	1,978	0	2,293	2,293	0	2,293	2,293
3)DEPARTMENT MANGEMENT	1,064	1,921	2,985	1,064	1,916	2,980	1,064	1,593	2,657	1,064	1,593	2,657
4)CIVIL RIGHTS	3,901	0	3,901	3,901	0	3,901	3,901	0	3,901	3,901	0	3,901
5)INSPECTOR GENERAL	10,400	10,000	20,400	10,400	10,000	20,400	10,400	10,000	20,400	10,400	10,000	20,400
6)OPM	0	85	85	0	85	85	0	85	85	0	85	85
7)PUBLIC HEALTH SERVICE	782	138	920	782	138	920	782	138	920	782	138	920
8)PROSPECTIVE PAYMENT COMMISSION	3,729	0	3,729	3,729	0	3,729	3,729	0	3,729	3,729	0	3,729
9)PHYSICIAN PAYMENT REVIEW COMM	0	2,977	2,977	0	2,977	2,977	0	2,977	2,977	0	2,977	2,977
SUBTOTAL, OTHER NON-HCFA ADMIN.	50,477	18,395	68,872	51,549	18,327	69,876	52,659	18,259	70,918	53,808	18,202	72,010
TOTAL NON-HCFA ADMINISTRATION	345,346	229,516	574,862	350,492	231,661	582,153	351,602	233,463	585,065	352,751	233,406	586,157
TOTAL OBLIGATIONS CURRENT LAW	1,244,761	1,624,638	2,869,399	1,347,834	1,880,668	3,228,502	1,440,455	2,145,457	3,585,912	1,545,243	2,451,824	3,997,067

OUTLAYS CURRENT LAW	FY 1988			FY 1989			FY 1990		
	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL
PEER REVIEW ORGANIZATIONS	170,526	18,947	189,473	253,996	67,518	321,514	241,648	64,235	305,883
1)RESEARCH	7,591	7,590	15,181	9,061	9,060	18,121	16,561	24,841	41,402
ADMINISTRATIVE ACTIVITIES									
1)PSRO									
2)CLAIMS PROCESSING	189,833	606,779	796,612	220,145	678,170	898,315	243,634	798,722	1,042,356
3)PAYMENT SAFEGUARDS	203,600	96,500	300,100	247,500	161,200	408,700	284,500	167,500	452,000
4)PRODUCTIVITY INVESTMENTS	19,800	35,100	54,900	18,600	31,700	50,300	35,100	42,400	77,500
5)STATE CERTIFICATION	41,943	4,973	46,916	45,067	5,344	50,411	66,498	8,472	74,970
6)ADMINISTRATIVE COSTS	103,649	69,636	173,285	121,644	81,727	203,371	136,266	91,550	227,816
7)CONTINGENCY FUNDS	(212)	(496)	(708)	0	0	(708)	0	0	0
TOTAL, ADMIN ACTIVITIES	558,613	812,492	1,371,105	652,956	958,141	1,610,389	765,998	1,108,644	1,874,642
TOTAL, RESEARCH/ADMIN	566,204	820,082	1,386,286	662,017	967,201	1,628,510	782,559	1,133,485	1,916,044
SOCIAL SECURITY ADMINISTRATION	285,583	200,740	486,323	200,740	200,740	401,480	293,934	208,595	502,529
OTHER NON-HCFA ADMINISTRATION									
1)TREASURY	29,246	1,190	30,436	29,600	1,507	31,107	30,108	1,292	31,400
2)RAILROAD RETIREMENT BOARD	0	1,500	1,500	0	1,978	1,978	0	2,314	2,314
3)DEPARTMENT MANGEMENT	5,939	4,589	10,528	1,064	1,939	3,003	1,064	1,596	2,660
4)CIVIL RIGHTS	3,901	0	3,901	3,901	0	3,901	3,901	0	3,901
5)INSPECTOR GENERAL	10,400	10,000	20,400	10,400	10,000	20,400	10,400	10,000	20,400
6)OPM	0	85	85	0	85	85	0	85	85
7)PUBLIC HEALTH SERVICE	782	138	920	782	138	920	782	138	920
8)PROSPECTIVE PAYMENT COMMISSION	4,665	0	4,665	3,729	0	3,729	3,729	0	3,729
9)PHYSICIAN PAYMENT REVIEW COMM	0	2,986	2,986	0	2,977	2,977	0	2,977	2,977
SUBTOTAL OTHER NON-HCFA ADMIN.	54,933	20,488	75,421	49,476	18,624	68,100	49,984	18,402	68,386
TOTAL NON-HCFA ADMINISTRATION	340,516	221,228	561,744	250,216	219,364	469,580	343,918	226,997	570,915
TOTAL OUTLAYS CURRENT LAW	906,720	1,041,310	1,948,030	912,233	1,186,565	2,098,090	1,126,477	1,360,482	2,486,959

OUTLAYS CURRENT LAW	FY 1991			FY 1992			FY 1993			FY 1994		
	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL
PEER REVIEW ORGANIZATIONS	278,323	73,985	352,308	300,943	79,998	380,941	290,363	77,186	367,549	329,354	87,550	416,904
1)RESEARCH	30,303	45,454	75,757	43,693	65,539	109,232	44,916	67,374	112,290	45,950	68,923	114,873
ADMINISTRATIVE ACTIVITIES												
1)PSRO												
2)CLAIMS PROCESSING	300,741	985,940	1,286,681	366,218	1,200,598	1,566,816	440,783	1,445,050	1,885,833	528,423	1,732,365	2,260,788
3)PAYMENT SAFEGUARDS	295,027	173,697	468,724	304,763	179,429	484,192	313,296	134,453	497,749	320,501	188,696	509,197
4)PRODUCTIVITY INVESTMENTS	36,259	43,799	80,058	37,274	45,026	82,300	38,131	46,062	84,193	39,008	47,121	86,129
5)STATE CERTIFICATION	68,825	8,768	77,593	70,890	9,031	79,921	72,591	9,248	81,839	74,334	9,470	83,804
6)ADMINISTRATIVE COSTS	137,947	92,680	230,627	139,419	93,669	233,088	140,663	94,505	235,168	141,935	95,359	237,294
7)CONTINGENCY FUNDS	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, ADMIN ACTIVITIES	838,799	1,304,884	2,143,683	918,564	1,527,753	2,446,317	1,005,464	1,779,318	2,784,782	1,104,201	2,073,011	3,177,212
TOTAL, RESEARCH/ADMIN	869,102	1,350,338	2,219,440	962,257	1,593,292	2,555,549	1,050,380	1,846,692	2,897,072	1,150,151	2,141,934	3,292,085
SOCIAL SECURITY ADMINISTRATION	294,869	211,121	505,990	298,942	213,334	512,276	302,094	214,702	516,796	302,094	214,702	516,796
OTHER NON-HCFA ADMINISTRATION												
1)TREASURY	30,601	1,296	31,897	31,673	1,233	32,906	32,783	1,173	33,956	33,932	1,116	35,048
2)RAILROAD RETIREMENT BOARD	0	1,978	1,978	0	1,978	1,978	0	2,293	2,293	0	2,293	2,293
3)DEPARTMENT MANGEMENT	1,064	1,921	2,985	1,064	1,916	2,980	1,064	1,593	2,657	1,064	1,593	2,657
4)CIVIL RIGHTS	3,901	0	3,901	3,901	0	3,901	3,901	0	3,901	3,901	0	3,901
5)INSPECTOR GENERAL	10,400	10,000	20,400	10,400	10,000	20,400	10,400	10,000	20,400	10,400	10,000	20,400
6)OPM	0	85	85	0	85	85	0	85	85	0	85	85
7)PUBLIC HEALTH SERVICE	782	138	920	782	138	920	782	138	920	782	138	920
8)PROSPECTIVE PAYMENT COMMISSION	3,729	0	3,729	3,729	0	3,729	3,729	0	3,729	3,729	0	3,729
9)PHYSICIAN PAYMENT REVIEW COMM	0	2,977	2,977	0	2,977	2,977	0	2,977	2,977	0	2,977	2,977
SUBTOTAL OTHER NON-HCFA ADMIN.	50,477	18,395	68,872	51,549	18,327	69,876	52,659	18,259	70,918	53,808	18,191	71,999
TOTAL NON-HCFA ADMINISTRATION	345,346	229,516	574,862	350,491	231,651	582,152	354,753	232,961	587,714	355,902	232,893	588,795
TOTAL OUTLAYS CURRENT LAW	1,214,448	1,579,854	2,794,302	1,312,748	1,824,953	3,137,701	1,405,133	2,079,653	3,484,786	1,506,053	2,374,827	3,880,880

	FY 1988			FY 1989			FY 1990		
OBLIGATIONS CURRENT SERVICES	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL
PEER REVIEW ORGANIZATIONS	339,694	37,744	377,438	498,032	132,388	630,420	517,455	137,551	655,006
1)RESEARCH	8,617	8,616	17,233	10,286	10,285	20,571	8,533	12,799	21,332
ADMINISTRATIVE ACTIVITIES									
1)PSRO	0	0	0	0	0	0	0	0	0
2)CLAIMS PROCESSING	196,983	629,634	826,617	475,320	456,680	932,000	225,900	740,584	966,484
3)PAYMENT SAFEGUARDS	203,600	96,500	300,100	247,500	161,200	408,700	266,764	157,058	423,822
4)PRODUCTIVITY INVESTMENTS	19,800	35,100	54,900	18,600	31,700	50,300	23,624	28,537	52,161
5)STATE CERTIFICATION	51,782	6,140	57,922	55,638	6,597	62,235	57,356	7,307	64,663
6)ADMINISTRATIVE COSTS	102,623	68,947	171,570	120,440	80,918	201,358	121,943	81,928	203,871
7)CONTINGENCY FUNDS/REIMB	(423)	(285)	(708)	0	0	0	0	0	0
TOTAL, ADMIN ACTIVITIES	574,365	836,036	1,410,401	917,498	737,095	1,654,593	695,588	1,015,413	1,711,001
TOTAL, RESEARCH/ADMIN	582,982	844,652	1,427,634	927,784	747,380	1,675,164	704,121	1,028,212	1,732,333
SOCIAL SECURITY ADMINISTRATION	279,901	203,162	483,063	285,256	200,740	485,996	293,934	208,595	502,529
OTHER NON-HCFA ADMINISTRATION									
1)TREASURY	29,246	1,190	30,436	30,387	1,236	31,623	31,481	1,280	32,761
2)RAILROAD RETIREMENT BOARD	0	1,500	1,500	0	1,559	1,559	0	1,615	1,615
3)DEPARTMENT MANGEMENT	5,939	4,589	10,528	6,171	4,768	10,939	6,393	4,940	11,333
4)CIVIL RIGHTS	3,901	0	3,901	4,053	0	4,053	4,199	0	4,199
5)INSPECTOR GENERAL	10,400	10,000	20,400	10,806	10,390	21,196	11,195	10,764	21,959
6)OPM	0	85	85	0	88	88	0	91	91
7)PUBLIC HEALTH SERVICE	782	138	920	812	143	955	841	148	989
8)PROSPECTIVE PAYMENT COMMISSION	4,665	0	4,665	4,847	0	4,847	5,021	0	5,021
9)PHYSICIAN PAYMENT REVIEW COMM	0	2,986	2,986	0	3,102	3,102	0	3,214	3,214
SUBTOTAL, OTHER NON-HCFA ADMIN.	54,933	20,488	75,421	57,076	21,286	78,362	59,130	22,052	81,182
TOTAL NON-HCFA ADMINISTRATION	334,834	223,650	558,484	342,332	222,026	564,358	353,064	230,647	583,711
TOTAL OBLIGATIONS CURRENT SERVICES	917,816	1,068,302	1,986,118	1,270,116	969,406	2,239,522	1,057,185	1,258,859	2,316,044

	FY 1991			FY 1992			FY 1993			FY 1994		
OBLIGATIONS CURRENT SERVICES	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL
PEER REVIEW ORGANIZATIONS	535,565	142,366	677,931	551,633	146,636	698,269	564,871	150,156	715,027	578,429	153,759	732,188
1)RESEARCH	8,814	13,222	22,036	9,061	13,592	22,653	9,270	13,904	23,174	9,270	13,904	23,174
ADMINISTRATIVE ACTIVITIES												
1)PSRO	0	0	0	0	0	0	0	0	0	0	0	0
2)CLAIMS PROCESSING	233,355	765,023	998,378	239,889	786,444	1,026,333	245,406	804,533	1,049,939	245,406	804,533	1,049,939
3)PAYMENT SAFEGUARDS	275,567	162,241	437,808	283,283	166,784	450,067	289,799	170,620	460,419	289,799	170,620	460,419
4)PRODUCTIVITY INVESTMENTS	24,403	29,479	53,882	25,087	30,304	55,391	25,664	31,001	56,665	25,664	31,001	56,665
5)STATE CERTIFICATION	59,363	7,563	66,926	61,144	7,790	68,934	62,612	7,977	70,589	62,612	7,977	70,589
6)ADMINISTRATIVE COSTS	123,371	82,887	206,258	124,622	83,727	208,349	125,679	84,437	210,116	125,679	84,437	210,116
7)CONTINGENCY FUNDS/REIMB	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, ADMIN ACTIVITIES	716,059	1,047,193	1,763,252	734,025	1,075,049	1,809,074	749,160	1,098,568	1,847,728	749,161	1,098,567	1,847,728
TOTAL, RESEARCH/ADMIN	724,873	1,060,415	1,785,288	743,086	1,088,641	1,831,727	758,430	1,112,472	1,870,902	758,430	1,112,472	1,870,902
SOCIAL SECURITY ADMINISTRATION	297,691	211,121	508,812	300,984	213,334	514,318	303,764	215,204	518,968	303,764	215,204	518,968
OTHER NON-HCFA ADMINISTRATION												
1)TREASURY	32,520	1,322	33,842	33,431	1,359	34,790	34,200	1,390	35,590	34,987	1,422	36,409
2)RAILROAD RETIREMENT BOARD	0	1,673	1,673	0	1,733	1,733	0	1,795	1,795	0	1,860	1,860
3)DEPARTMENT MANGEMENT	6,623	5,118	11,741	6,861	5,302	12,163	7,108	5,493	12,601	7,364	5,691	13,055
4)CIVIL RIGHTS	4,350	0	4,350	4,507	0	4,507	4,669	0	4,669	4,837	0	4,837
5)INSPECTOR GENERAL	11,598	11,152	22,750	12,016	11,553	23,569	12,449	11,969	24,418	12,897	12,400	25,297
6)OPM	0	94	94	0	97	97	0	100	100	0	104	104
7)PUBLIC HEALTH SERVICE	871	153	1,024	902	159	1,061	934	165	1,099	968	171	1,139
8)PROSPECTIVE PAYMENT COMMISSION	5,202	0	5,202	5,389	0	5,389	5,583	0	5,583	5,784	0	5,784
9)PHYSICIAN PAYMENT REVIEW COMM	0	3,330	3,330	0	3,450	3,450	0	3,574	3,574	0	3,703	3,703
SUBTOTAL, OTHER NON-HCFA ADMIN.	61,164	22,842	84,006	63,106	23,653	86,759	64,943	24,486	89,429	66,837	25,351	92,188
TOTAL NON-HCFA ADMINISTRATION	358,855	233,963	592,818	364,090	236,987	601,077	368,707	239,690	608,397	370,601	240,555	611,156
TOTAL OBLIGATIONS CURRENT SERVICES	1,083,728	1,294,378	2,378,106	1,107,176	1,325,628	2,432,804	1,127,137	1,352,162	2,479,299	1,129,031	1,353,027	2,482,058

OUTLAYS CURRENT SERVICES	FY 1988 HI	 SMI	 TOTAL	FY 1989 HI	 SMI	 TOTAL	FY 1990 HI	 SMI	 TOTAL
PEER REVIEW ORGANIZATIONS	170,526	18,947	189,473	253,996	67,518	321,514	621,981	165,336	787,317
1)RESEARCH	7,591	7,590	15,181	9,061	9,060	18,121	7,517	11,275	18,792
ADMINISTRATIVE ACTIVITIES									
1)PSRO	0	0	0	0	0	0	0	0	0
2)CLAIMS PROCESSING	189,833	606,779	796,612	475,320	456,680	932,000	217,623	713,451	931,074
3)PAYMENT SAFEGUARDS	203,600	96,500	300,100	247,500	161,200	408,700	266,764	157,058	423,822
4)PRODUCTIVITY INVESTMENTS	19,800	35,100	54,900	18,600	31,700	50,300	23,624	28,537	52,161
5)STATE CERTIFICATION	41,943	4,973	46,916	45,067	5,344	50,411	46,458	5,919	52,377
6)ADMINISTRATIVE COSTS	103,649	69,636	173,285	106,098	71,281	177,379	123,163	82,747	205,910
7)CONTINGENCY FUNDS	(423)	(285)	(708)	0	0	0	0	0	0
TOTAL, ADMIN ACTIVITIES	558,402	812,703	1,371,105	892,585	726,205	1,618,790	677,632	987,712	1,665,344
TOTAL, RESEARCH/ADMIN	565,993	820,293	1,386,286	901,646	735,265	1,636,911	685,149	998,987	1,684,136
SOCIAL SECURITY ADMINISTRATION	285,583	203,162	483,063	282,451	200,740	485,996	213,334	208,595	502,529
OTHER NON-HCFA ADMINISTRATION									
1)TREASURY	29,246	1,190	30,436	30,387	1,236	31,623	31,481	1,280	32,761
2)RAILROAD RETIREMENT BOARD	0	1,500	1,500	0	1,559	1,559	0	1,615	1,615
3)DEPARTMENT MANGEMENT	5,939	4,589	10,528	5,135	4,768	10,939	5,367	4,940	11,333
4)CIVIL RIGHTS	3,901	0	3,901	4,053	0	4,053	4,199	0	4,199
5)INSPECTOR GENERAL	10,400	10,000	20,400	10,806	10,390	21,196	11,195	10,764	21,959
6)OPM	0	85	85	0	88	88	0	91	91
7)PUBLIC HEALTH SERVICE	732	138	920	812	143	955	841	148	989
8)PROSPECTIVE PAYMENT COMMISSION	4,665	0	4,665	4,847	0	4,847	5,021	0	5,021
9)PHYSICIAN PAYMENT REVIEW COMM	0	2,986	2,986	0	2,977	2,977	0	3,214	3,214
SUBTOTAL OTHER NON-HCFA ADMIN.	54,933	20,488	75,421	56,040	21,161	78,362	58,104	16,458	81,182
TOTAL NON-HCFA ADMINISTRATION	340,516	223,650	558,484	338,491	221,901	564,358	271,438	225,053	583,711
TOTAL OUTLAYS CURRENT SERVICES	906,509	1,043,943	1,944,770	1,240,137	957,166	2,201,269	956,587	1,224,040	2,267,847

OUTLAYS CURRENT SERVICES	FY 1991			FY 1992			FY 1993			FY 1994		
	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL	HI	SMI	TOTAL
PEER REVIEW ORGANIZATIONS	621,255	165,145	786,400	345,322	91,794	437,116	690,837	183,641	874,478	676,183	179,745	855,928
1)RESEARCH	7,764	11,647	19,411	7,982	11,973	19,955	8,166	12,248	20,414	8,166	12,248	20,414
ADMINISTRATIVE ACTIVITIES												
1)PSRO	0	0	0	0	0	0	0	0	0	0	0	0
2)CLAIMS PROCESSING	224,805	736,993	961,798	231,099	757,629	988,728	236,414	775,055	1,011,469	236,415	775,054	1,011,469
3)PAYMENT SAFEGUARDS	275,567	162,241	437,808	283,283	166,784	450,067	289,799	170,620	460,419	289,799	170,620	460,419
4)PRODUCTIVITY INVESTMENTS	24,403	29,479	53,882	25,087	30,304	55,391	25,664	31,001	56,665	25,664	31,001	56,665
5)STATE CERTIFICATION	48,084	6,126	54,210	49,527	6,310	55,837	50,716	6,461	57,177	50,716	6,461	57,177
6)ADMINISTRATIVE COSTS	124,605	83,716	208,321	125,868	84,564	210,432	126,936	85,281	212,217	126,936	85,282	212,218
7)CONTINGENCY FUNDS	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL, ADMIN ACTIVITIES	697,464	1,018,555	1,716,019	714,864	1,045,591	1,760,455	729,529	1,068,418	1,797,947	729,530	1,068,418	1,797,948
TOTAL, RESEARCH/ADMIN	705,228	1,030,202	1,735,430	722,846	1,057,564	1,780,410	737,695	1,080,666	1,818,361	737,696	1,080,666	1,818,362
SOCIAL SECURITY ADMINISTRATION	297,691	211,121	508,812	300,984	213,334	514,318	303,764	215,204	518,968	303,764	215,204	518,968
OTHER NON-HCFA ADMINISTRATION												
1)TREASURY	32,520	1,322	33,842	33,431	1,359	34,790	34,200	1,390	35,590	34,987	1,422	36,409
2)RAILROAD RETIREMENT BOARD	0	1,673	1,673	0	1,733	1,733	0	1,795	1,795	0	1,860	1,860
3)DEPARTMENT MANGEMENT	5,591	5,118	11,741	5,920	5,302	12,163	6,070	5,493	12,601	6,326	5,691	13,055
4)CIVIL RIGHTS	4,350	0	4,350	4,507	0	4,507	4,669	0	4,669	4,837	0	4,837
5)INSPECTOR GENERAL	11,598	11,152	22,750	12,016	11,553	23,569	12,449	11,969	24,418	12,897	12,400	25,297
6)OPM	0	94	94	0	97	97	0	100	100	0	104	104
7)PUBLIC HEALTH SERVICE	871	153	1,024	902	159	1,061	934	165	1,099	968	171	1,139
8)PROSPECTIVE PAYMENT COMMISSION	5,202	0	5,202	5,389	0	5,389	5,583	0	5,583	5,784	0	5,784
9)PHYSICIAN PAYMENT REVIEW COMM	0	3,330	3,330	0	3,450	3,450	0	3,574	3,574	0	3,703	3,703
SUBTOTAL OTHER NON-HCFA ADMIN.	60,132	17,142	84,006	62,165	17,900	86,759	63,905	18,733	89,429	65,799	19,598	92,188
TOTAL NON-HCFA ADMINISTRATION	357,823	228,263	592,818	363,149	231,234	601,077	367,669	233,937	608,397	369,563	234,802	611,156
TOTAL OUTLAYS CURRENT SERVICES	1,063,051	1,258,465	2,328,248	1,085,995	1,288,798	2,381,487	1,105,364	1,314,603	2,426,758	1,107,259	1,315,468	2,429,518

TRUST FUND TRANSFER PERCENTAGES

	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
PRO	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
RESEARCH	64.2854%	64.2844%	77.0492%	83.3430%	85.3824%	85.3824%	85.3824%
CLAIMS PRO	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
PAY SAFE	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
PROD INVEST	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
STATE CERT	87.9485%	94.4973%	93.3833%	93.3833%	93.3833%	93.3833%	93.3833%
ESRD	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
ADMIN	69.8451%	71.1241%	73.4528%	73.4528%	73.4528%	73.4528%	73.4528%
CONTINGENCY	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%

GENERAL FUND OBLIGATIONS TO OUTLAYS

	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
RESEARCH	129.8300%	115.0000%	80.0000%	80.0000%	80.0000%	80.0000%	80.0000%
STATE CERT	56.0000%	60.0000%	56.0000%	56.0000%	56.0000%	56.0000%	56.0000%
ADMIN	104.0000%	104.0000%	104.0000%	104.0000%	104.0000%	104.0000%	104.0000%

HI PERCENTAGE OF TRUST FUND OBLIGATIONS

	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
RESEARCH	50.0000%	50.0000%	40.0000%	40.0000%	40.0000%	40.0000%	40.0000%
PRO	90.0000%	79.0000%	79.0000%	79.0000%	79.0000%	79.0000%	79.0000%
CLAIMS PRO	23.8300%	24.5064%	23.3734%	23.3734%	23.3734%	23.3734%	23.3734%
PAY SAFE	67.8441%	60.5579%	62.9425%	62.9425%	62.9425%	62.9425%	62.9425%
PROD INVEST	36.0656%	36.9781%	45.2903%	45.2903%	45.2903%	45.2903%	45.2903%
STATE CERT	89.4000%	89.4000%	88.7000%	88.7000%	88.7000%	88.7000%	88.7000%
ESRD	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%
ADMIN	59.8140%	59.8140%	59.8140%	59.8140%	59.8140%	59.8140%	59.8140%
ADMIN PP	59.8139%	59.8139%	59.8139%	59.8139%	59.8139%	59.8139%	59.8139%
CONTINGENCY	30.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%

TRUST FUND OBLIGATIONS TO OUTLAYS

	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994	C.S.ADJ
RESEARCH	88.0900%	88.0900%	88.0900%	88.0900%	88.0900%	88.0900%	88.0900%	95.8298%
PRO	50.2000%	51.0000%	120.2000%	116.0000%	62.6000%	122.3000%	116.9000%	36.8354%
CLAIMS PRO	96.3701%	96.3857%	96.3360%	96.3360%	96.3360%	96.3360%	96.3360%	96.3734%
PAY SAFE	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	96.3362%
PROD INVEST	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
STATE CERT	81.0000%	81.0000%	81.0000%	81.0000%	81.0000%	81.0000%	81.0000%	70.2052%
ESRD	80.0000%	80.0000%	80.0000%	80.0000%	80.0000%	80.0000%	80.0000%	74.5902%
ADMIN	101.0000%	101.0000%	101.0000%	101.0000%	101.0000%	101.0000%	101.0000%	95.8306%
CONTINGENCY	100.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	50.0000%

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INFLATION FACTORS

	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
PRO	3.8000%	4.1000%	3.9000%	3.5000%	3.0000%	2.4000%	2.4000%
RESEARCH	4.3000%	4.1000%	3.7000%	3.3000%	2.8000%	2.3000%	2.3000%
CLAIMS PRO	4.3000%	4.1000%	3.7000%	3.3000%	2.8000%	2.3000%	2.3000%
PAY SAFE	4.3000%	4.1000%	3.7000%	3.3000%	2.8000%	2.3000%	2.3000%
PROD INVEST	4.3000%	4.1000%	3.7000%	3.3000%	2.8000%	2.3000%	2.3000%
STATE CERT	3.8000%	4.1000%	3.9000%	3.5000%	3.0000%	2.4000%	2.4000%
ESRD	3.8000%	4.1000%	3.9000%	3.5000%	3.0000%	2.4000%	2.4000%
ADMIN							
PAY	2.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%	0.0000%
NON-PAY	3.3000%	3.9000%	3.6000%	3.3000%	2.8000%	2.3000%	2.3000%
% PAY	68.9296%	65.3309%	64.5257%	63.7789%	63.1386%	62.6077%	62.0738%
% NON-PAY	31.0704%	34.6691%	35.4743%	36.2211%	36.8614%	37.3923%	37.9262%
CONTINGENCY	4.3000%	4.1000%	3.7000%	3.3000%	2.8000%	2.3000%	2.3000%

CURRENT SERVICES TRUST FUND TRANSFER PERCENTAGES

	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
PSRO	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
RESEARCH	64.2854%	64.2844%	64.2844%	64.2844%	64.2844%	64.2844%	64.2844%
CLAIMS PRO	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
PAY SAFE	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
PROD INVEST	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
STATE CERT	87.9485%	94.4973%	94.4973%	94.4973%	94.4973%	94.4973%	94.4973%
ESRD	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%
ADMIN	69.8451%	71.1241%	71.1241%	71.1241%	71.1241%	71.1241%	71.1241%
CONTINGENCY	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%	100.0000%

SUMMARY

FY 1990
GRANTS TO STATES FOR MEDICAID

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FY 1990 REQUEST

GRANTS TO STATES FOR MEDICAID
(SOCIAL SECURITY ACT, TITLE XIX, SECTION 1901)

AUTHORIZATION: INDEFINITE

(Dollars in Thousands)

Program Activity	FY 1989 Pending Request	FY 1989 Current Estimate	FY 1990 Request	Difference
Medical Assistance Payments	$31,068,237	$31,807,656	$34,866,746	3,059,090
State and Local Administration*	1,664,352	1,687,891	1,772,696	84,805
Total Current Law Requirements	32,732,589	33,495,547	36,639,442	3,143,895
Proposed Legislation**	0	0	20,000	20,000
Total Requirements, Net of Proposed Law	32,732,589	33,495,547	36,659,442	3,163,895

* Includes funding for State Certification and State Fraud Control.

** Reflects the impact of the Medicare SMI premium proposal.

HIGHLIGHTS OF THE FY 1990 REQUEST

- This submission is based on the May 1988 State estimates which present revised projections for FY 1988 and FY 1989 and, for the first time, State projections for FY 1990. During subsequent quarters, the States will update their FY 1990 estimates.

- The May 1988 State estimates project total State and Federal FY 1990 Medicaid costs of approximately $66 billion.

- The adjusted Federal share of Medicaid costs in FY 1990 is estimated to be $36.6 billion under current law. This amount represents an increase of $3.1 billion over the current law estimate of $33.5 billion for FY 1989.

- Actuarial estimates from the President's FY 1989 budget continue to be used for the outyears FY 1991-94. These estimates will be updated for the FY 1988 Mid-Session Review.

EXPLANATION OF THE ESTIMATES

Estimates of the Federal share of Medicaid costs are developed in a two-step process. The first step is to reduce the State estimates by specified percentage to compensate for overestimation. The second step is to measure the impact of initiatives, regulations and recently enacted laws which are not reflected in the State estimates.

Adjusted May 1988 State Estimates

The May estimates have been reduced by 0.5 percent, the same percentage reduction applied to the November estimates used in the President's FY 1989 budget.

A comparison of the adjusted May estimates with the adjusted November estimates (President's Budget) is shown on Table 1.

Medicaid Survey and Certification

The current FY 1990 estimate for this activity is $76.4 million, of which $19.8 million is for new survey and certification requirements imposed by OBRA '87.

The current FY 1989 estimate is $58.4 million, of which $5.5 million is for new survey and certification requirements imposed by OBRA '87.

State Medicaid Fraud Control Units

The current FY 1990 estimate for this activity is $47.7 million which is the same as the current FY 1989 estimate.

Current Law Adjustments

Various program and financial adjustments are made to the adjusted May 1988 State estimates in order to arrive at an accurate estimate of Medicaid expenditures. A comparison of estimates for current law outlays with those in the President's 1989 budget is presented on Table 1.

TABLE 1

CURRENT LAW OUTLAYS

($ In Thousands)

	FY 1988			FY 1989			FY 1990		
	Pres Budget	Current Estimate	Change	Pres Budget	Current Estimate	Change	Pres Budget	Current Estimate	Change
Adjusted State Estimates									
Medical Assistance Payments	28,847,034	29,108,321	261,287	31,483,287	32,026,956	543,669	34,318,552	34,852,346	533,794
State/Local Administration	1,499,583	1,517,505	17,922	1,572,936	1,610,416	37,480	1,634,287	1,677,921	43,634
Subtotal, Adj State Est	30,346,617	30,625,826	279,209	33,056,223	33,637,372	581,149	35,952,839	36,530,267	577,428
Current Law Adjustments									
Prior Year Claims	6,700	6,700	0	0	0	0	-	-	0
MEQC Disallowances	(9,200)	0	9,200	(3,800)	(3,800)	0	(15,000)	(19,600)	(4,600)
Financial Adjustments	361,518	93,020	(268,498)	-	-	0	-	-	0
Medicaid Initiatives	(215,000)	(72,700)	142,300	(721,250)	(529,100)	192,150	(897,500)	(609,300)	288,200
OBRA '87 (w/o survey provs)	79,000	71,000	(8,000)	310,000	296,000	(14,000)	642,000	625,000	(17,000)
Cost Allocation Savings	0	0	0	(11,000)	(11,000)	0	(11,000)	(11,000)	0
Subtotal, Current Law Adj	223,018	98,020	(124,998)	(426,050)	(247,900)	178,150	(281,500)	(14,900)	266,600
State Certification									
Base	48,544	49,260	716	51,711	52,870	1,159	53,700	56,570	2,870
OBRA '87	0	0	0	3,000	5,500	2,500	40,000	19,800	(20,200)
Subtotal, State Cert	48,544	49,260	716	54,711	58,370	3,659	93,700	76,370	(17,330)
State Fraud Control	45,453	45,453	0	47,705	47,705	0	49,600	47,705	(1,895)
Total, Current Law Outlays	30,663,632	30,818,559	154,927	32,732,589	33,495,547	762,958	35,814,639	36,639,442	824,803

CURRENT LAW ADJUSTMENTS

1. Medicaid Eligibility Quality Control (MEQC) Disallowances

The President's FY 1989 budget assumed that $9.2 million in FY 1981 penalties would be collected in FY 1988. The Departmental Grants Appeals Board, however, has ruled on a number of issues related to these disallowances and remanded the case back to HCFA. New error rates must be recalculated and issued. States will be allowed to appeal, if they wish, the new error rates.

The DGAB decision will delay the collection of disallowances related to the FY 1981 penalties until FY 1990. Therefore, no savings from MEQC disallowances are now shown in FY 1988. In addition, it is estimated that the DGAB decision will reduce the States' liability in half, from $9.2 million to $4.6 million. Therefore, in FY 1990, $19.6 million is expected to be collected ($15 million in prospective withholdings plus $4.6 million in FY 1981 penalties). These changes are presented below:

($ in millions)

	FY 1988	FY 1989	FY 1990
MEQC Disallowances			
President's FY 1989 Budget	$9.2	$3.8	$15.0
Current Estimate	-0-	$3.8	$19.6

2. OBRA '87 Provisions

The estimate for the cost of the OBRA '87 provisions has been reduced from $313 million to $301.5 million in FY 1989 and from $682 million to $644.8 million in FY 1990. This reduction reflects the following changes:

- The provision on payments to the territories has been dropped because the May 1988 State estimates now reflect this cost.
- The estimate for the provision on the increased match (from 75 percent to 90 percent) for survey and certification activities has been reduced. The President's Budget included an estimate for this provision, provided by the Congressional Budget Office, which had assumed an effective date of October 1, 1989 for the enhanced matching. The statutory language of OBRA '87, however, provided for an effective date of October 1, 1990. Other costs for the new survey and certification requirements have also been repriced based upon more recent data.

TABLE 2

SAVINGS FROM MEDICAID INITIATIVES

($ In Thousands)

INITIATIVE	Current Savings Estimate	
	FY 1989	FY 1990
Second Surgical Opinions	(15,000)	(30,000)
Prescription Drug Reform	0	0
Medicaid Fin Mgt Reviews	(193,000)	(170,000)
Payments to Institutions	(35,000)	(50,000)
Medically Needy Income Level	(22,500)	(45,000)
Limit on Donations	(176,000)	(186,000)
MMIS Funding Restriction	(17,600)	(18,300)
Survey/Cert Disallowances	0	0
State Tax Disallowances	0	0
Liens/Estate Recoveries	(20,000)	(40,000)
Ambulatory Surgery/Preadmission Testing/Same Day Surgery	(20,000)	(40,000)
Disallow FFP for Non-Med Svcs in ICF/MR's	(30,000)	(30,000)
Subtotal, Medicaid Initiatives	(529,100)	(609,300)

3. Medicaid Initiatives

A number of Medicaid initiatives have been repriced for various reasons. In some instances, savings are now reflected in the May 1988 State estimates. In other instances, savings estimates have been adjusted to reflect more recent information on the impact of the initiatives or revised schedules for publishing regulations. A detailed explanation is provided below.

Prescription Drug Reform

The savings from this initiative are now reflected in the May 1988 State estimates because the final rule, published in the Federal Register on July 31, 1987, with an effective date of October 29, 1987, has been operative for more than six months.

Medicaid Financial Management Reviews

The increased effort in this area is yielding a large return. As a result of the rigorous financial management reviews, there has been significant change in State behavior, e.g., some States are withdrawing claims for recipients in institutions for mental disease. The success of this initiative can be gauged from the May 1988 estimates which, for FY 1988, reflect savings to date of $112.3 million.

The current FY 1990 savings estimate is $170 million.

Medically Needy Income Levels for Single Persons

The current FY 1989 savings estimate for this initiative is $22.5 million, or half of the savings estimate of $45 million reflected in the President's budget. This change is due to an expected delay in publishing the final rule. The original estimate assumed a full-year implementation in FY 1989. This will not be possible since the proposed rule is not expected to be published until the end of September 1988.

The current FY 1990 savings estimate of $45 million remains unchanged from the President's 1989 budget.

MMIS Funding Restriction

This initiative is expected to save $18.3 million in FY 1990. The savings have been reduced from the level reflected in the President's FY 1989 budget as a result of more recent data on the impact of this initiative on state systems, particularly those subject to the 75 percent match.

Survey and Certification Disallowances

Like many other types of disallowances, which are not scored, and which vary with specific situations, these disallowances are part of ongoing audit activities and are more appropriately reflected in the estimated finalizations for the current year. Therefore, this line item adjustment has been dropped.

Liens/Estate Recoveries

This initiative on encouraging States to use their current authority to impose liens and make estate recoveries will be patterned after the successful third party liability program. A number of actions have already been done. A presentation on liens and estate recoveries was made at the May State Medicaid Directors conference. Also, a Successful Practices Guide, which detailed estate recovery methods, was sent in May to State agencies and national organizations.

A number of other actions are planned. These include assessments of current State practices, direct technical assistance and discussion at appropriate national forums. In addition, HCFA will be working with a Department group on liens and estate recoveries.

The FY 1990 savings estimate for this initiative is $40 million. This estimate is lower than an earlier estimate included in the President's FY 1989 budget. The reason for the difference is that the earlier estimate had assumed savings from actions that have since been determined to require statutory changes, e.g., making lien and estate recovery programs mandatory for the States.

Ambulatory Surgery/Preadmission Testing/Same Day Surgery

This initiative is expected to reduce costs by shifting, where feasible and safe, inpatient hospital services to an outpatient setting. A number of actions are planned. In FY 1989, HCFA will produce and disseminate a summary of State programs on containing the costs of elective surgeries. This summary will be based on a review of the pertinent literature and a survey of State Medicaid agencies. In FY 1990, HCFA will promote adoption of effective State programs through letters to appropriate State officials, meetings with national organizations, regional conferences and follow-up activities with the States.

The FY 1990 savings estimate for this initiative is $40 million. This estimate is lower than an earlier estimate included in the President's FY 1989 budget for a number of reasons.

Ambulatory Surgery/Preadmission Testing/Same Day Surgery (cont.)

First, the original estimate had assumed that, of the 26 States without a ambulatory surgery program, half would put one in place if given sufficient encouragement. The current estimate is more realistic and assumes that only a third would implement such a program.

Second, the original estimate had assumed that, of the 30 States that could benefit from a preadmission testing/same day surgery program, all would implement it if given sufficient encouragement. The current estimate is more realistic and assumes that only half of the 30 States would implement the initiative.

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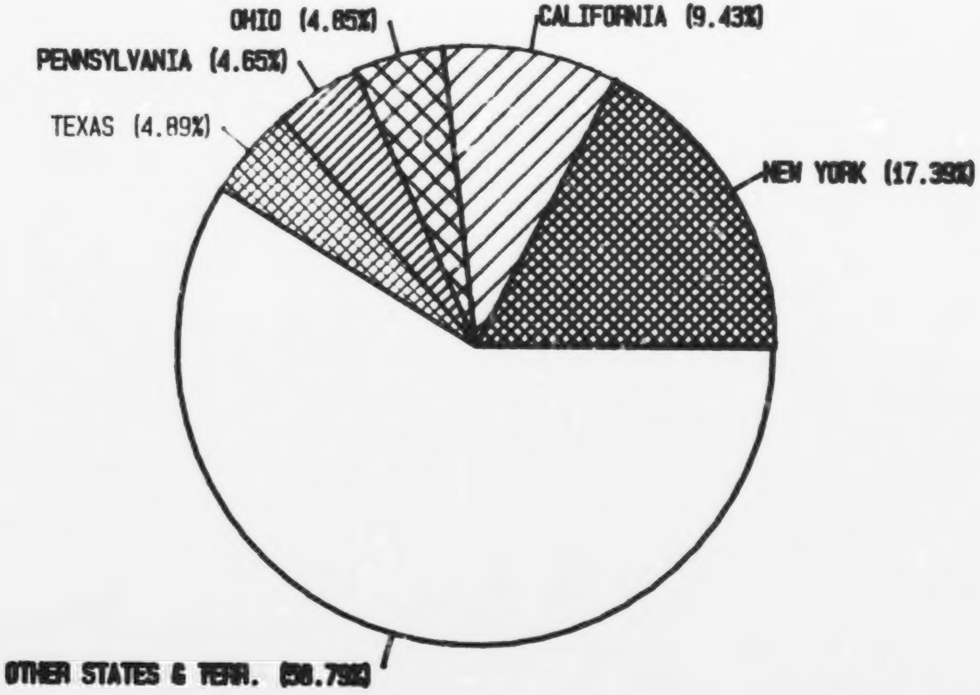
DISTRIBUTION OF ESTIMATED FY 90 MEDICAID OUTLAYS
STATES WITH ESTIMATED OUTLAYS OVER $1.5 BILLION



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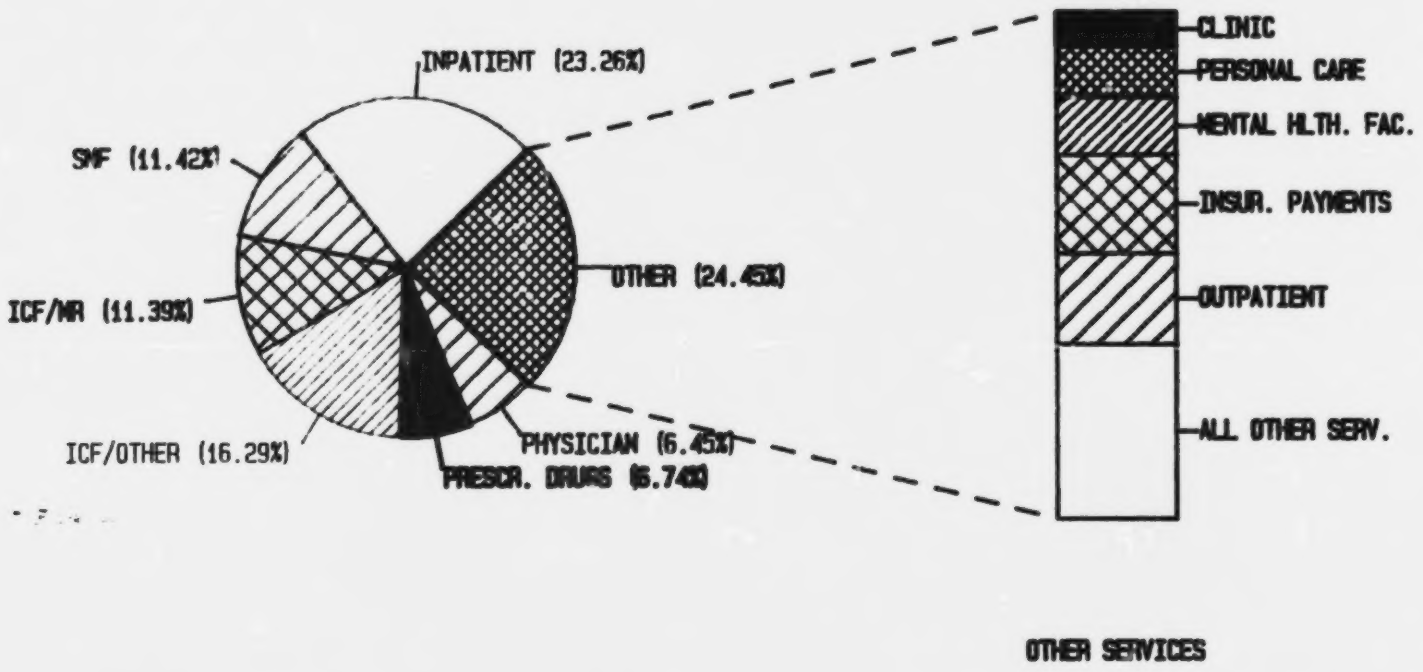
DISTRIBUTION OF MEDICAID SERVICES
ESTIMATED FOR FY 1989



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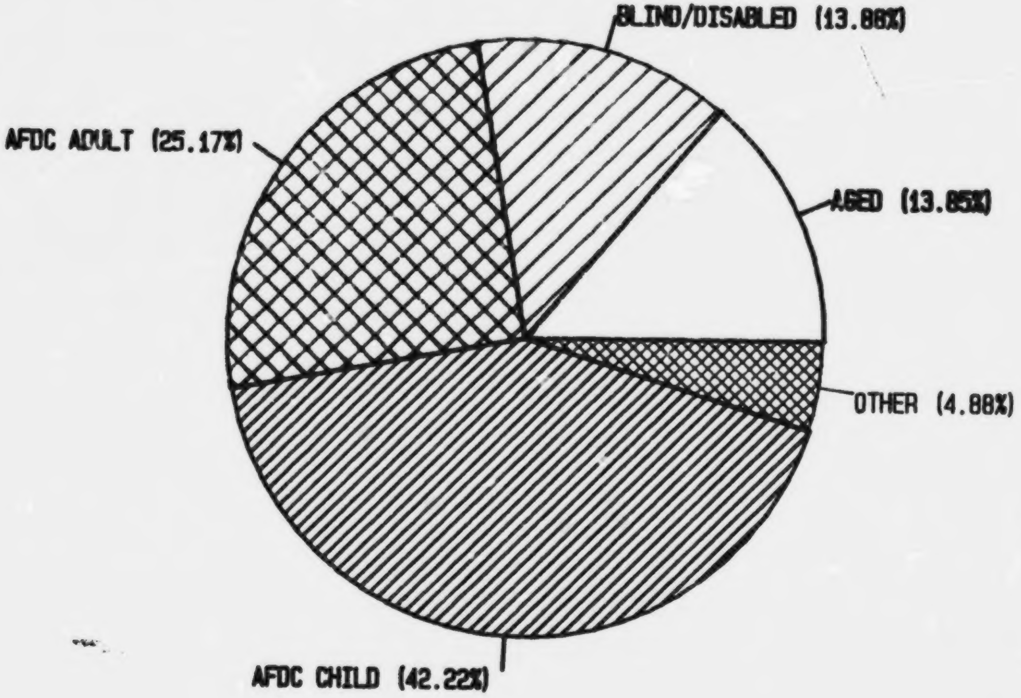
ESTIMATED FY 89 MAP
$31.8 BILLION

DISTRIBUTION OF MEDICAID ELIGIBILITY GROUPS
ESTIMATED FOR FY 1989



ESTIMATED FY 89
UNDUPLICATED RECIPIENTS: 24,996,000

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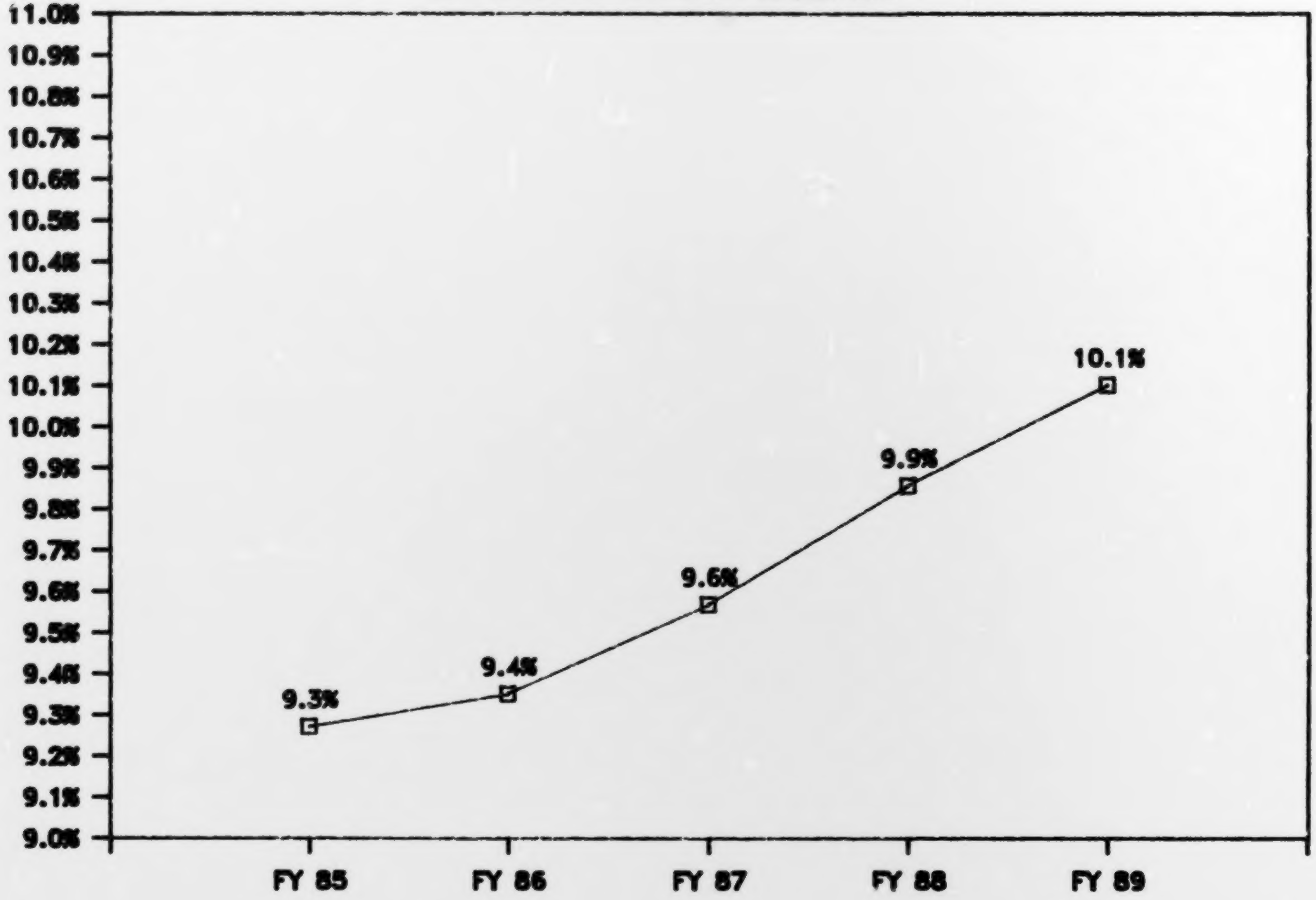
MEDICAID RECIPIENTS

AS A PERCENT OF U.S. POPULATION



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MEDICAID

FY 1990

PAYMENTS TO THE HEALTH CARE TRUST FUNDS

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PAYMENTS TO TRUST FUNDS

Payments to Health Care Trust Funds
(Dollars in millions)

	FY 88	FY 89 Current Est.	FY 90 Request	Change From FY 89
Supplementary Medical Insurance	$25,418	$31,292	$34,339	+3,047
Hospital Insurance for the Uninsured	461	493	377	-116
Federal Uninsured Payment	14	22	35	+13
Total Appropriation	$25,893	$31,807	$34,751	+2,944

This appropriation covers three Federal payments to the Health Care Trust Funds. Two of the three payments in FY 1990 are for the Hospital Insurance (HI) Trust Fund. The payments for the uninsured put the Hospital Insurance Trust Fund in the same financial position it would have been in had it not had to bear the cost of benefits chargeable to Federal Funds. The third payment is for Federal matching of premiums paid by or for individuals enrolled in the voluntary Supplementary Medical Insurance program.

- Federal Payment for Supplementary Medical Insurance (SMI) - provides Federal matching for premiums paid by Part B enrollees. The premiums and the Federal contribution finance the benefits and the administrative costs of the SMI trust fund. Transfer of funds is done on a daily basis to be concurrent with the receipt of premium payments. Specifically, 95 percent of the total matching is tied to the deduction from the Social Security and Railroad Retirement checks, and matching usually occurs on the third of the month. The remaining 5 percent is matched when the premiums are received. A special match or transfer payment plus interest is paid on December 31 in those cases where there is a shortfall in the prior years' appropriation. During calendar year (CY) 1990 the monthly premium payment per enrollee not counting catastrophic coverage, is expected to be $28.90 while the Federal payment will be $93.30 and $55.10 for the aged and disabled, respectively.

  The request for FY 1990 of $34,339 million represents an increase of $3,047 million or 9.7 percent over the current estimate for FY 1989. This increase reflects the projected impact of the most recent technical updates which revised the FY 1989 President's Budget. These technical updates also reflect a reduction of $293 million in the Federal contribution from the President's budget. These updates assume that the FY 1989 appropriation is adequate and that a part of the

FY 1990 appropriation is not needed to fund a shortfall in FY 1989.

Under current law the annual increase in the SMI premium after 1989 cannot be greater than the COLA rate of increase in Social Security benefits. In addition, the SMI premium is prohibited from increasing the beneficiary's cost beyond the COLA and the Federal contribution must make up the difference. (This refers to the hold harmless provision of the statute.) The FY 1990 Federal Contribution totaling $34,339 reflects the additional revenue needed to cover program expenditures due to the hold harmless provision. If our outlay savings proposals and the proposal to maintain the premium at 25 percent of estimated expenditures are enacted, then the Federal contribution would be reduced $663 million in FY 1990 and $15.0 billion through FY 1994.

- Hospital Insurance for the Uninsured - provides reimbursement to the Hospital Insurance Trust Fund (Part A) to cover the cost of providing coverage to certain individuals who were grandfathered into the program.

  The request for FY 1990 of $377 million is $116 million or 23.5 percent lower than FY 1989. The decline in the number of uninsured from 201,000 to 166,000 offsets the increase in the program costs for the remaining group due to inflation and higher utilization.

- Federal Uninsured Payment - When the Social Security Act was amended by P.L. 97-248 to extend Medicare coverage to Civil Service annuitants, a transitional provision was created for individuals who had worked for the Federal government prior to 1983 and who were employed during January 1983. The provision allows these individuals to receive credit toward Medicare coverage for noncontributory quarters worked in the Federal government.

  The amendment authorized an appropriation to the Hospital Insurance Trust Fund to cover the cost of: benefits to these individuals, associated administrative costs, and an interest payment that would put the trust fund in the same position at the end of the fiscal year as it would have been if transitional coverage were not available.

  The request for FY 1990 of $35 million, an increase of $13 million or 59 percent over FY 1989, reflects application increases as Federal annuitants reach the age of eligibility and elect Medicare coverage.

MEDICARE BENEFITS

FY 1990

MEDICARE BENEFITS

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Medicare Benefits Overview

Medicare benefits under current law will total $106.0 billion during FY 1990, an increase of $11.7 billion or 12.5 percent over FY 1989.

Estimated Benefits
(Dollars in millions)

	FY 88 Current Est.	FY 89 Current Est.	FY 90 Current Law	FY 90 Proposed Law
Part A	$52,040	$55,750	$62,305	$61,045
Part B	$34,009	$38,526	$43,715	$42,158
Total	$86,049	$94,276	$106,020	$103,203

Rates of Benefit Increase

	FY 88	FY 89	FY 90
Part A	4.5%	7.1%	11.8%
Part B	13.6%	13.3%	13.5%
Total Medicare	7.9%	9.6%	12.5%

The 12.5 percent Medicare increase for FY 1990 reflects a greater number of enrollees, increased benefits per enrollee, and greater intensity and utilization of health services. The program will experience more rapid FY 1990 growth, ranging from 18 to 33 percent, in some smaller health service components such as group practice, independent lab and hospice. In particular, the cost of outpatient services, which account for $9.5 billion or about one fifth of the Supplemental Medical Insurance (SMI) program in FY 1990, will increase by 18 percent over FY 1989.

These estimates incorporate technical base re-estimates of the FY 1989 President's Budget, including upward revisions of the number of enrollees, the case mix of enrollee admissions, and the benefit payment per enrollee admission.

Beyond these increases, we are proposing Medicare benefit savings for FY 1990 of $2.9 billion, and for FY 1990 through FY 1994 of $26.5 billion. In addition, two income proposals will generate $2.0 billion in FY 1990 and $23.3 billion in FY 1990 through FY 1994. These savings estimates reflect the following assumptions:

- an extension of the OBRA of 1987 provision on capital costs and new proposals focusing on control of growth in the SMI program produce $1.4 billion in FY 1990 savings, substantially exceeding HCFA's $1.0 billion share of the $2.5 billion HHS savings target; and
- proposals from the FY 1989 President's Budget will have their effective dates slipped one year, and are repriced to reflect changes in the Medicare baseline.

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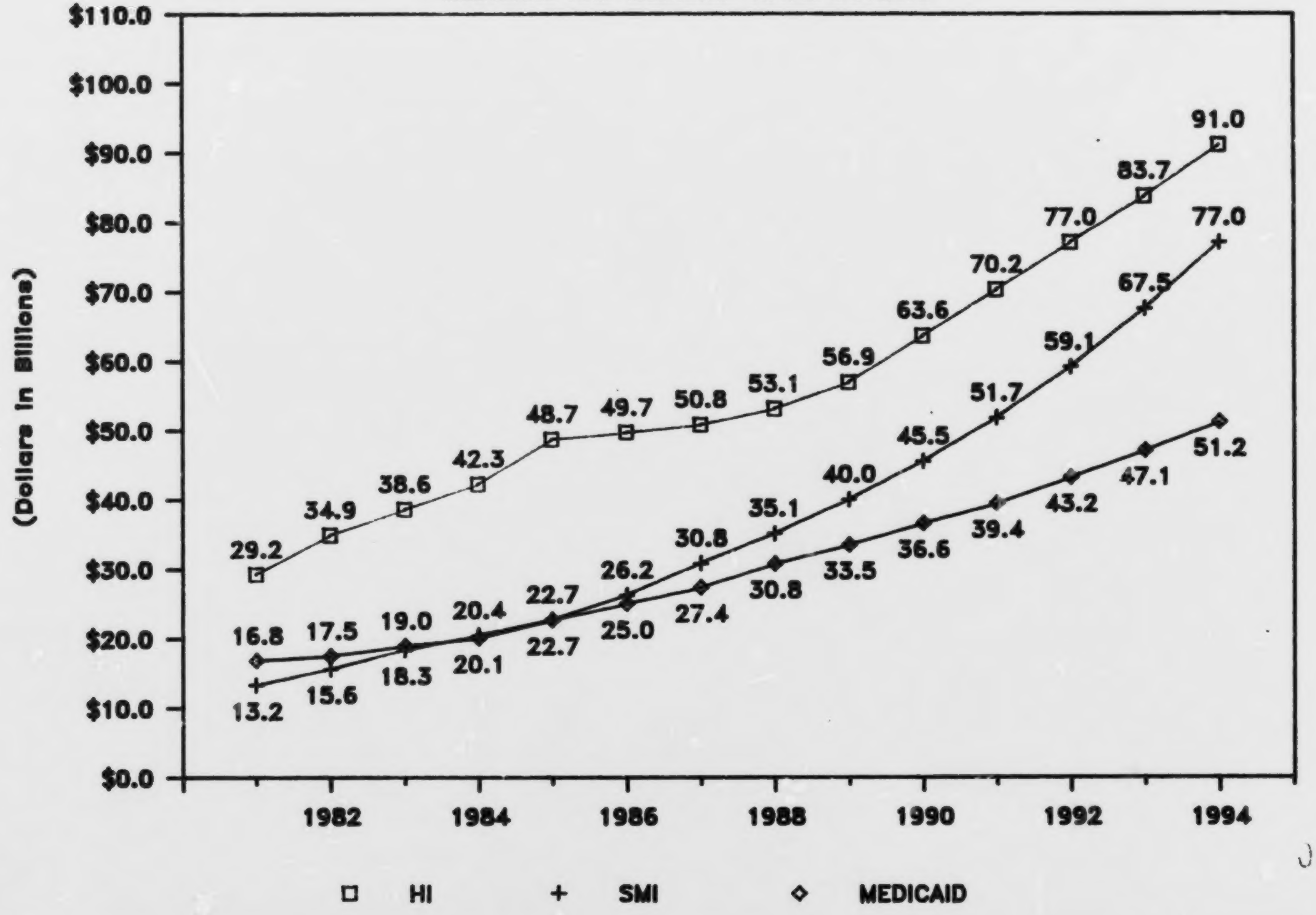
HEALTH CARE FINANCING ADMINISTRATION

MEDICARE AND MEDICAID TOTAL OUTLAYS



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MEDICARE BENEFITS - HISTORIC OUTLAYS AND PROJECTIONS

(Dollars in Millions)

	FY 1967	FY 1968	FY 1969	FY 1970	FY 1971	FY 1972	FY 1973	FY 1974	FY 1975	FY 1976	TQ 1976	FY 1977	FY 1978	FY 1979	FY 1980
HOSPITAL INSURANCE BENEFIT OUTLAYS	2,508	3,736	4,654	4,804	5,442	6,108	6,648	7,806	10,353	12,267	3,315	14,906	17,411	19,891	23,790
% CHANGE		49.0%	24.6%	3.2%	13.3%	12.2%	8.8%	17.4%	32.6%	18.5%	17.2%	16.7%	16.8%	14.2%	19.6%
SUPPLEMENTARY MEDICAL INSURANCE BENEFIT OUTLAYS	664	1,390	1,645	1,979	2,035	2,255	2,391	2,874	3,765	4,672	1,269	5,867	6,852	8,259	10,144
% CHANGE		109.3%	18.3%	20.3%	2.8%	10.8%	6.0%	20.2%	31.0%	24.1%	N/A	N/A	16.8%	20.5%	22.8%
TOTAL MEDICARE BENEFIT OUTLAYS	3,172	5,126	6,299	6,783	7,477	8,363	9,039	10,680	14,118	16,939	4,584	20,773	24,263	28,150	33,934
% CHANGE		61.6%	22.9%	7.7%	10.2%	11.8%	8.1%	18.2%	32.2%	20.0%	N/A	N/A	16.8%	16.0%	20.5%

	FY 1981	FY 1982	FY 1983	FY 1984	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
HOSPITAL INSURANCE BENEFIT OUTLAYS	28,907	34,343	38,102	41,461	47,710	48,867	49,804	52,040	55,750	62,305	68,764	75,359	81,943	89,102
PIP ADJUSTMENT			38,942	41,541	46,768									
% CHANGE	21.5%	18.8%	10.9%	8.8%	15.1%	2.4%	1.9%	4.5%	7.1%	11.8%	10.4%	9.6%	8.7%	8.7%
PIP ADJUSTMENT			13.1%	6.7%	12.6%	4.5%								
SUPPLEMENTARY MEDICAL INSURANCE BENEFIT OUTLAYS	12,345	14,806	17,487	19,473	21,808	25,169	29,932	34,009	38,526	43,715	49,907	57,159	65,267	74,506
% CHANGE	21.7%	19.9%	18.1%	11.4%	12.0%	15.4%	18.9%	13.6%	13.3%	13.5%	14.2%	14.5%	14.2%	14.2%
TOTAL MEDICARE BENEFIT OUTLAYS	41,252	49,149	55,589	60,934	69,518	74,036	79,736	86,049	94,276	106,020	118,671	132,518	147,210	163,608
PIP ADJUSTMENT			56,429	61,014	68,576									
% CHANGE	21.6%	19.1%	13.1%	9.6%	14.1%	6.5%	7.7%	7.9%	9.6%	12.5%	11.9%	11.7%	11.1%	11.1%
PIP ADJUSTMENT			14.8%	8.1%	12.4%	8.0%								

Hospital Insurance

The Hospital Insurance (HI) program pays for inpatient hospital care and other related care of those aged 65 and over, and of the long term disabled, including ESRD recipients. In calendar year 1990, about 30 million people aged 65 and over and about 3 million disabled people under age 65 will be covered under HI. The HI program is financed primarily by the contributions of 136 million workers and their employers through payroll taxes.

HI benefits for FY 1990 are projected to be $62.3 billion. This represents a $6.6 billion or 11.8 percent increase over FY 1989.

The following list details the increases for FY 1990:

- the technical base re-estimate increases FY 1990 benefit outlays by $1.5 billion,
- inpatient hospital services are projected to be $58.4 billion, an increase of 11.9 percent,
- Skilled Nursing Facility (SNF) services are projected to be $733 million, an increase of 8.1 percent,
- home health services are projected to be $3.0 billion, an increase of 8.6 percent, and
- hospice services will be $160 million, an increase of 33.3 percent.

Between FY 1989 and FY 1990, benefits per enrollee will increase 9.6 percent to $1,875 per enrollee. However, only 23.4 percent of all HI enrollees will receive benefits. The average benefit per enrollee receiving benefits is much higher. For the aged it is $7,964 and for the disabled (including the ESRD beneficiaries) it is $8,283.

The outyear current law projections show the annual rate of HI program growth falling from 11.8 percent in FY 1990 to 8.7 percent in FY 1994. The increase in the outyears is driven by the hospital market basket, increasing enrollment, and utilization. In FY 1990 and after, the annual PPS update factor is equal to the hospital market basket under current law. The number of enrollees receiving benefits will increase from 7.8 million in FY 1990 to 8.5 million in FY 1993, an increase of 9.1 percent, and will reach 24.3 percent of total HI enrollees. The benefits per enrollee receiving benefits will increase by 20.6 percent from $7,998 in FY 1990 to $9,646 in FY 1993.

The HI current law trust fund income in FY 1990 will be $78.5 billion. The major sources for this income are payroll taxes ($70.0 billion) and interest payments ($7.3 billion). The remaining consists primarily of transfers from the Railroad Retirement account ($0.3 billion) and the general fund transfers ($0.8 billion). The end of year cash balance is estimated to be $96.9 billion in FY 1990 and to increase to $135.6 billion in FY 1993.

The tables present current law estimates. In FY 1990 we also estimate $2.1 billion in savings resulting from an extension of the OBRA of 1987 provision on capital costs, new proposals, and a one year delay in the legislative proposals contained in the FY 1989 President's Budget. For the FY 1990 to FY 1994 period, these savings would total $16.6 billion.

In addition, a HI income proposal would generate $1.4 billion in FY 1990 and $9.6 billion during the period of FY 1990 to FY 1994. This proposal resubmits legislation requiring all State and local employees to pay into the HI trust fund.

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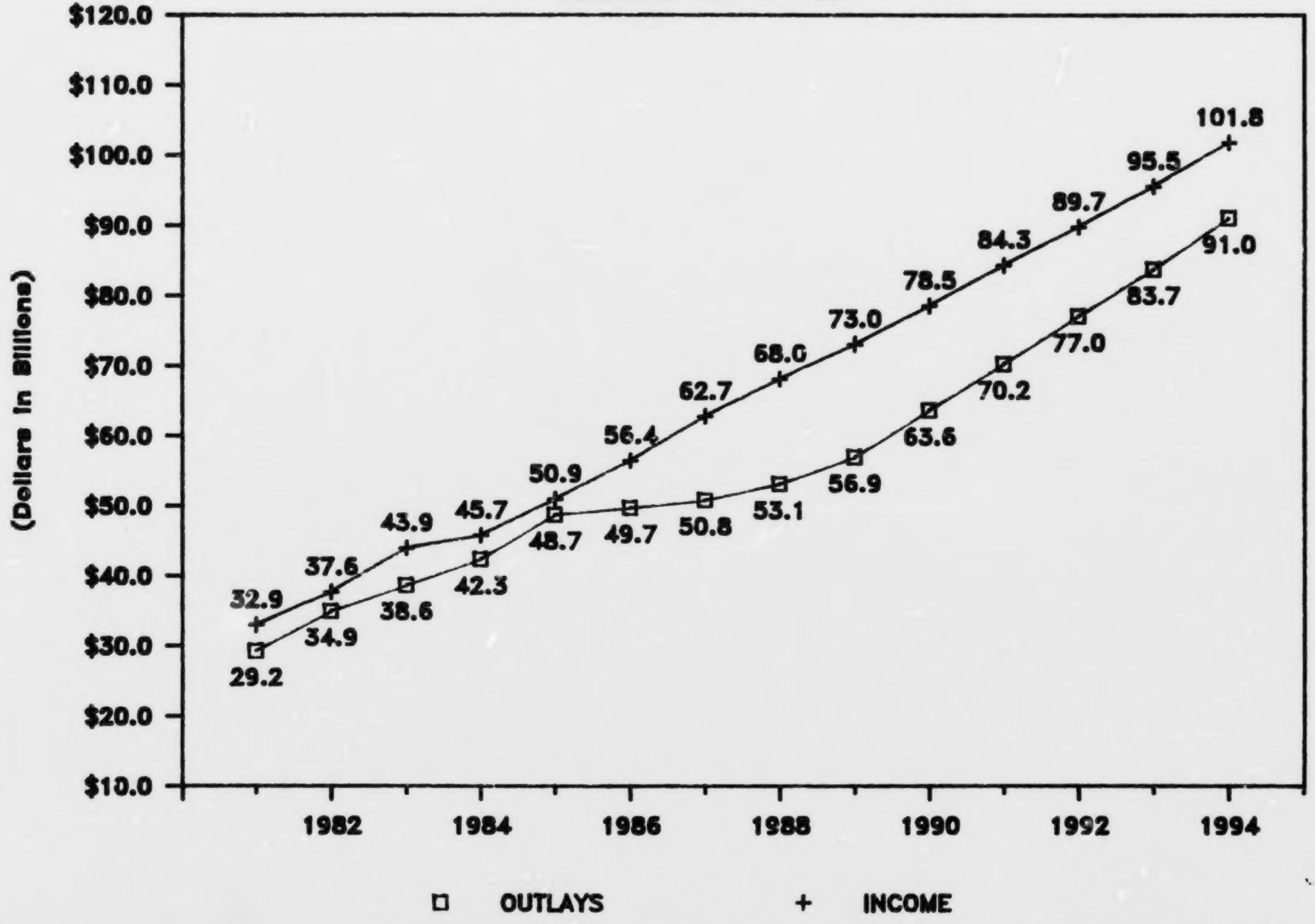
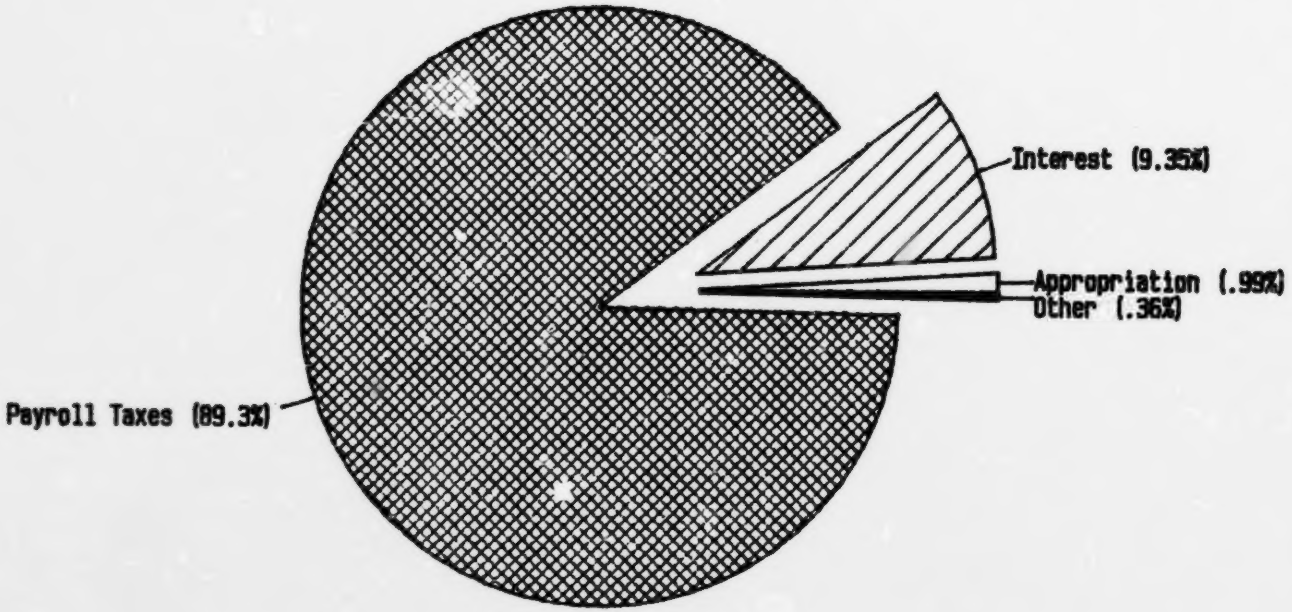
HEALTH CARE FINANCING ADMINISTRATION

MEDICARE PART A – HI



HI INCOME BY SOURCE

FY 1990 INCOME $78,532



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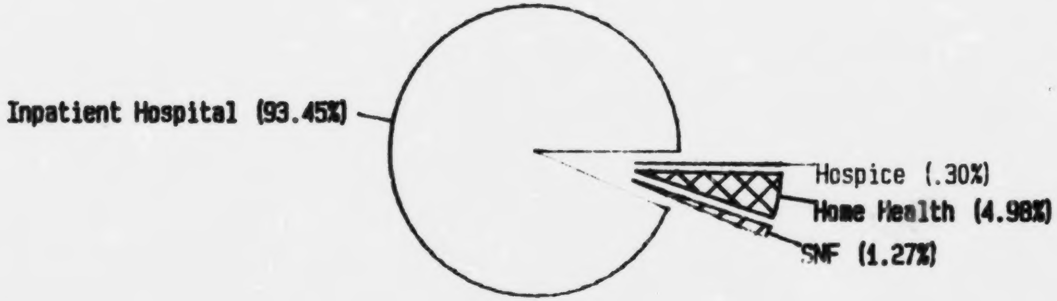
(Dollars in Millions)

HI BENEFIT OUTLAYS BY TYPE OF SERVICE
TOTAL FY 1990 BENEFIT OUTLAYS $62, 305

(in millions)



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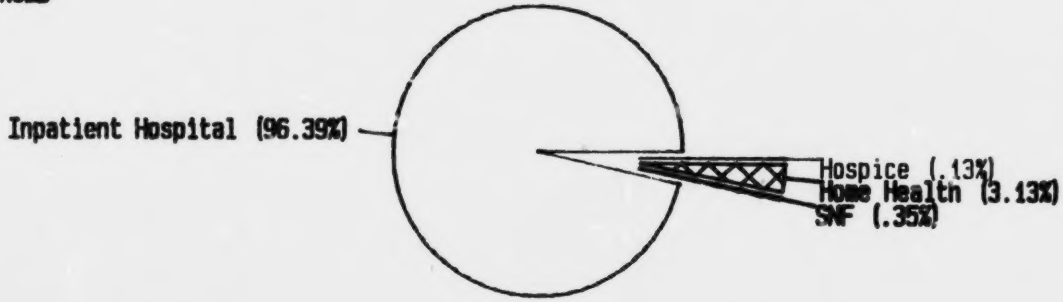

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DISABLED

TABLE A1 - HISTORICAL MEDICARE PART A OUTLAYS BY SERVICE
(DOLLARS IN MILLIONS)

	FY 1967	FY 1968	FY 1969	FY 1970	FY 1971	FY 1972	FY 1973	FY 1974	FY 1975	FY1976	TQ 1976	FY 1977	FY 1978	FY 1979	FY 1980
INPATIENT HOSPITAL	2,393	3,348	4,239	4,452	5,182	5,887	6,412	7,513	9,947	11,742	3,171	14,266	16,697	19,091	22,864
% CHANGE		39.9%	26.6%	5.0%	16.4%	13.6%	8.9%	17.2%	32.4%	18.0%	N/A	N/A	17.0%	14.3%	19.8%
SKILLED NURSING FACILITIES	97	344	367	298	214	174	179	214	273	308	81	351	353	363	387
% CHANGE		254.6%	6.7%	-18.8%	-28.2%	-18.7%	2.9%	19.6%	27.6%	12.8%	N/A	N/A	0.6%	2.8%	6.6%
HOME HEALTH	13	36	48	54	46	47	57	79	133	217	63	289	361	437	539
% CHANGE		176.9%	33.3%	12.5%	-14.8%	2.2%	21.3%	38.6%	68.4%	63.2%	N/A	N/A	24.9%	21.1%	23.3%
OUTPATIENT	5	8													
% CHANGE		60.0%													
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TOTAL HOSPITAL INSURANCE BENEFITS	2,508	3,736	4,654	4,804	5,442	6,108	6,648	7,806	10,353	12,267	3,315	14,906	17,411	19,891	23,790
% CHANGE		49.0%	24.6%	3.2%	13.3%	12.2%	8.8%	17.4%	32.6%	18.5%	17.2%	16.7%	16.8%	14.2%	19.6%

	FY 1981	FY 1982	FY 1983	FY 1984	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
INPATIENT HOSPITAL	27,764	32,720	36,076	39,080	45,017	46,042	46,692	48,792	52,209	58,433	64,523	70,724	76,898	83,602
PIP ADJUSTMENT			36,916	39,160	44,075									
% CHANGE	21.4%	17.9%	10.3%	8.3%	15.2%	2.3%	1.4%	4.5%	7.0%	11.9%	10.4%	9.6%	8.7%	8.7%
PIP ADJUSTMENT			12.8%	6.1%	12.6%	4.5%								
SKILLED NURSING FACILITIES	428	462	511	535	567	568	592	622	678	733	796	862	928	999
% CHANGE	10.6%	7.9%	10.6%	4.7%	6.0%	0.2%	4.2%	5.1%	9.0%	8.1%	8.6%	8.3%	7.7%	7.7%
HOME HEALTH	715	1,161	1,515	1,844	2,111	2,222	2,457	2,536	2,743	2,979	3,235	3,503	3,777	4,072
% CHANGE	32.7%	62.4%	30.5%	21.7%	14.5%	5.3%	10.6%	3.2%	8.2%	8.6%	8.6%	8.3%	7.8%	7.8%
HOSPICE			0	2	15	35	63	90	120	160	210	270	340	428
% CHANGE				100.0%	100.0%	133.3%	80.0%	42.9%	33.3%	33.3%	31.3%	28.6%	25.9%	25.9%
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TOTAL HOSPITAL INSURANCE BENEFITS	28,907	34,343	38,102	41,461	47,710	48,867	49,804	52,040	55,750	62,305	68,764	75,359	81,943	89,102
PIP ADJUSTMENT			38,942	41,541	46,768									
% CHANGE	21.5%	18.8%	10.9%	8.8%	15.1%	2.4%	1.9%	4.5%	7.1%	11.8%	10.4%	9.6%	8.7%	8.7%
PIP ADJUSTMENT			13.1%	6.7%	12.6%	4.5%								

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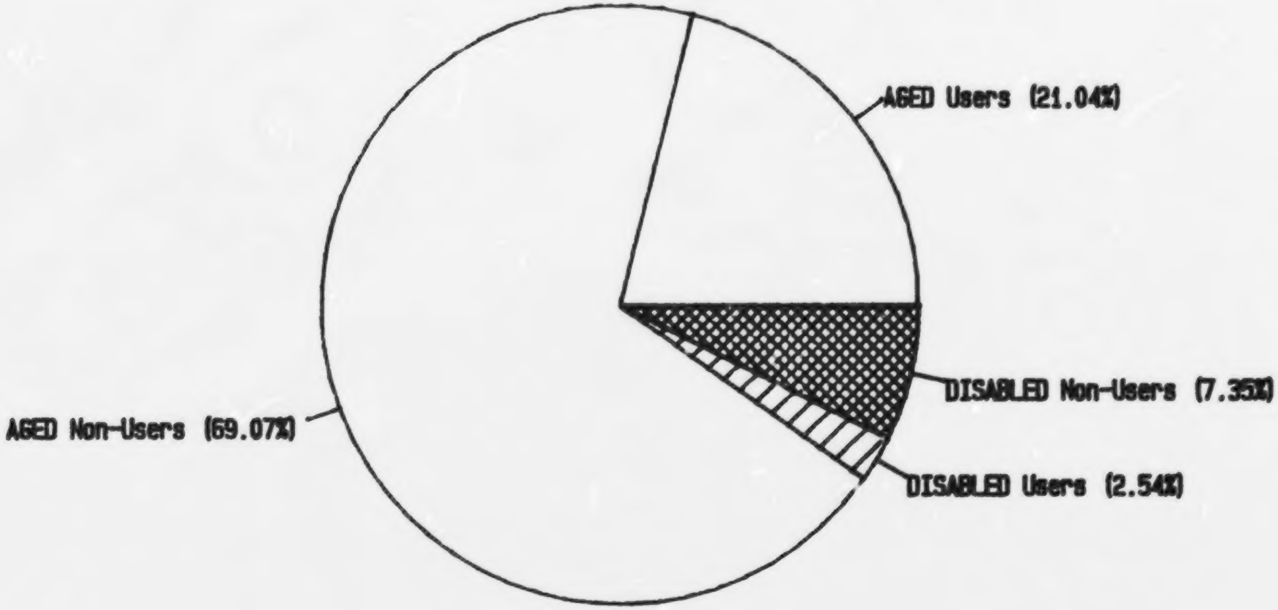
HI ENROLLEES

FY 1990 TOTAL 33,228

(in thousands)



AGED Receiving Benefits (Users) 6,950
Disabled Receiving Benefits (Users) 840
Total Receiving Benefits 7,790

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TABLE A2 - HI ENROLLEE DATA
(ENROLLEES IN THOUSANDS)

HI ENROLLEES	AVE % CHANGE 77-86	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89	FY 1991	% CHANGE FROM '90	FY 1992	% CHANGE FROM '91	FY 1993	% CHANGE FROM '92	FY 1994	% CHANGE FROM '93
o AGED																	
- Insured	2.5%	27,910	1.6%	28,576	2.4%	29,187	2.1%	29,759	2.0%	30,298	1.8%	30,805	1.7%	31,289	1.6%	31,781	1.6%
- Uninsured	-11.2%	286	-11.2%	242	-15.4%	201	-16.9%	166	-17.4%	133	-19.9%	109	-18.0%	88	-19.3%	71	-19.3%
- Fed Uninsured	NA	8	33.3%	11	37.5%	16	45.5%	22	37.5%	29	31.8%	36	24.1%	40	11.1%	44	10.0%
- Self Pay	2.5%	18	-18.2%	18	0.0%	19	5.6%	19	0.0%	20	5.3%	20	0.0%	20	0.0%	20	0.0%
SUBTOTAL	2.2%	28,222	1.4%	28,847	2.2%	29,423	2.0%	29,966	1.8%	30,480	1.7%	30,970	1.6%	31,437	1.5%	31,916	1.5%
o DISABLED																	
- Disabled	0.8%	2,952	1.4%	2,994	1.4%	3,105	3.7%	3,212	3.4%	3,290	2.4%	3,366	2.3%	3,447	2.4%	3,530	2.4%
- ESRD	5.0%	42	35.5%	45	7.1%	48	6.7%	50	4.2%	52	4.0%	54	3.8%	56	3.7%	58	3.6%
SUBTOTAL	0.8%	2,994	1.8%	3,039	1.5%	3,153	3.8%	3,262	3.5%	3,342	2.5%	3,420	2.3%	3,503	2.4%	3,588	2.4%
TOTAL ENROLLEES	2.0%	31,216	1.4%	31,886	2.1%	32,576	2.2%	33,228	2.0%	33,822	1.8%	34,390	1.7%	34,940	1.6%	35,504	1.6%
HI ENROLLEES RECEIVING BENEFITS																	
o AGED	1.8%	6,390	0.3%	6,540	2.3%	6,740	3.1%	6,950	3.1%	7,170	3.2%	7,370	2.8%	7,570	2.7%	7,775	2.7%
o DISABLED																	
- age 21 - 65		746	1.4%	761	2.0%	796	4.6%	836	5.0%	866	3.6%	891	2.9%	921	3.4%	952	3.4%
- under 21		4	0.0%	4	0.0%	4	0.0%	4	0.0%	4	0.0%	4	0.0%	4	0.0%	4	0.0%
SUBTOTAL	1.8%	750	1.4%	765	2.0%	800	4.6%	840	5.0%	870	3.6%	895	2.9%	925	3.4%	956	3.4%
TOTAL RECEIVING BENEFITS	1.8%	7,140	0.4%	7,305	2.3%	7,540	3.2%	7,790	3.3%	8,040	3.2%	8,265	2.8%	8,495	2.8%	8,731	2.8%
TOTAL AS PERCENT OF ENROLLEES		22.9%		22.9%		23.1%		23.4%		23.8%		24.0%		24.3%		24.6%	

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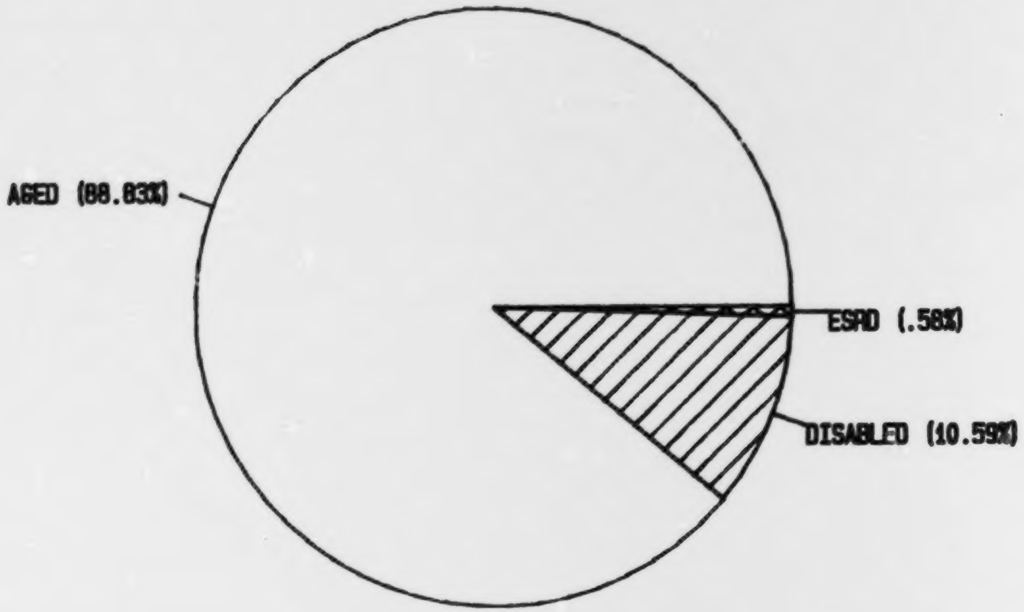
HI BENEFIT OUTLAYS

Overall Average $1,875



BENEFITS BY ENROLLEE GROUP:	Average Benefit Per Enrollee	Number of Enrollees (thousands)	Total Benefits ($ in millions)
Aged	$1,847	29,966	$55,347
Disabled	$2,056	3,212	$6,604
ESRD	$7,080	50	$354
TOTAL:	$1,875	33,228	$62,305

TABLE A3a - HI BENEFITS BY TYPE OF ENROLLEE

TOTAL BENEFITS PER ENROLLEE CATEGORY
(BENEFITS IN MILLIONS)
(with PIP)

TYPE OF ENROLLEE	AVE % CHANGE 77-86	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89	FY 1991	% CHANGE FROM '90	FY 1992	% CHANGE FROM '91	FY 1993	% CHANGE FROM '92	FY 1994	% CHANGE FROM '93
o AGED																	
- Insured *	NA	43,753	2.4%	45,842	4.8%	49,141	7.2%	54,930	11.8%	60,676	10.5%	66,551	9.7%	72,386	8.8%	78,719	8.7%
- Uninsured	NA	538	-11.5%	471	-12.5%	416	-11.7%	376	-9.6%	329	-12.5%	286	-13.1%	249	-12.9%	217	-12.9%
- Self Pay	NA	32	-11.1%	35	9.4%	37	5.7%	41	10.8%	46	12.2%	50	8.7%	54	8.0%	58	7.4%
SUBTOTAL	15.9%	44,323	2.2%	46,348	4.6%	49,594	7.0%	55,347	11.6%	61,051	10.3%	66,887	9.6%	72,689	8.7%	78,994	8.7%
o DISABLED																	
- Disabled	16.5%	5,195	0.3%	5,388	3.7%	5,827	8.1%	6,604	13.3%	7,329	11.0%	8,056	9.9%	8,803	9.3%	9,619	9.3%
- ESRD	17.3%	286	-10.3%	304	6.3%	329	8.2%	354	7.6%	384	8.5%	416	8.3%	451	8.4%	489	8.4%
SUBTOTAL	16.6%	5,481	-0.3%	5,692	3.8%	6,156	8.2%	6,958	13.0%	7,713	10.9%	8,472	9.8%	9,254	9.2%	10,108	9.2%
TOTAL BENEFITS	16.0%	49,804	1.9%	52,040	4.5%	55,750	7.1%	62,305	11.8%	68,764	10.4%	75,359	9.6%	81,943	8.7%	89,102	8.7%

BENEFITS PER ENROLLEE
(BENEFITS IN DOLLARS)

TYPE OF ENROLLEE	AVE % CHANGE 77-86	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89	FY 1991	% CHANGE FROM '90	FY 1992	% CHANGE FROM '91	FY 1993	% CHANGE FROM '92	FY 1994	% CHANGE FROM '93
o AGED																	
- Insured	NA	1,568	0.8%	1,604	2.3%	1,684	5.0%	1,846	9.6%	2,003	8.5%	2,160	7.9%	2,313	7.1%	2,477	7.1%
- Uninsured	NA	1,830	-1.3%	1,862	1.7%	1,917	3.0%	2,000	4.3%	2,031	1.5%	1,972	-2.9%	1,945	-1.4%	1,887	-3.0%
- Self Pay	NA	1,778	8.6%	1,944	9.4%	1,947	0.2%	2,158	10.8%	2,300	6.6%	2,500	8.7%	2,700	8.0%	2,900	7.4%
ALL AGED	13.2%	1,571	0.8%	1,607	2.3%	1,686	4.9%	1,847	9.6%	2,003	8.4%	2,160	7.8%	2,312	7.1%	2,475	7.0%
o DISABLED																	
- Disabled	14.6%	1,760	-1.2%	1,800	2.3%	1,877	4.3%	2,056	9.6%	2,228	8.3%	2,393	7.4%	2,554	6.7%	2,725	6.7%
- ESRD	11.0%	6,810	-33.8%	6,756	-0.8%	6,854	1.5%	7,080	3.3%	7,385	4.3%	7,704	4.3%	8,054	4.5%	8,431	4.7%
ALL DISABLED	14.6%	1,831	-2.1%	1,873	2.3%	1,952	4.2%	2,133	9.3%	2,308	8.2%	2,477	7.3%	2,642	6.6%	2,817	6.6%
ALL ENROLLEES	13.3%	1,595	0.5%	1,632	2.3%	1,711	4.9%	1,875	9.6%	2,033	8.4%	2,191	7.8%	2,345	7.0%	2,510	7.0%

BENEFITS PER ENROLLEE RECEIVING BENEFITS
(BENEFITS IN DOLLARS)
(with PIP)

TYPE OF ENROLLEE	AVE % CHANGE 77-86	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89	FY 1991	% CHANGE FROM '90	FY 1992	% CHANGE FROM '91	FY 1993	% CHANGE FROM '92	FY 1994	% CHANGE FROM '93
o AGED	13.5%	6,936	1.9%	7,087	2.2%	7,358	3.8%	7,964	8.2%	8,515	6.9%	9,076	6.6%	9,602	5.8%	10,160	5.8%
o DISABLED	13.3%	7,308	-1.7%	7,441	1.8%	7,695	3.4%	8,283	7.6%	8,866	7.0%	9,456	6.8%	10,004	5.7%	10,573	5.7%
ALL ENROLLEES	13.5%	6,975	1.5%	7,124	2.1%	7,394	3.8%	7,998	8.2%	8,553	6.9%	9,118	6.6%	9,646	5.8%	10,205	5.8%

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TABLE A4a - HI BENEFITS BY TYPE OF SERVICE
(BENEFITS IN MILLIONS)
(with PIP)

	AVE % CHANGE 77-86	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89	FY 1991	% CHANGE FROM '90	FY 1992	% CHANGE FROM '91	FY 1993	% CHANGE FROM '92	FY 1994	% CHANGE FROM '93
o INPATIENT HOSPITAL																	
- Aged *	15.7%	41,413	1.5%	43,310	4.6%	46,281	6.9%	51,726	11.8%	57,086	10.4%	62,552	9.6%	67,970	8.7%	73,848	8.6%
- Disabled	16.2%	5,279	0.9%	5,482	3.8%	5,928	8.1%	6,707	13.1%	7,437	10.9%	8,172	9.9%	8,928	9.3%	9,754	9.3%
SUBTOTAL	15.8%	46,692	1.4%	48,792	4.5%	52,209	7.0%	58,433	11.9%	64,523	10.4%	70,724	9.6%	76,898	8.7%	83,602	8.7%
o SKILLED NURSING FACILITIES																	
- Aged	6.2%	572	4.4%	601	5.1%	655	9.0%	708	8.1%	769	8.6%	833	8.3%	896	7.6%	964	7.6%
- Disabled	5.5%	20	0.0%	21	5.0%	23	9.5%	25	8.7%	27	8.0%	29	7.4%	32	10.3%	35	10.3%
SUBTOTAL	6.2%	592	4.2%	622	5.1%	678	9.0%	733	8.1%	796	8.6%	862	8.3%	928	7.7%	999	7.7%
o HOME HEALTH																	
- Aged	29.0%	2,278	10.7%	2,352	3.2%	2,544	8.2%	2,761	8.5%	2,997	8.5%	3,246	8.3%	3,500	7.8%	3,774	7.8%
- Disabled	29.3%	179	9.1%	184	2.8%	199	8.2%	218	9.5%	238	9.2%	257	8.0%	277	7.8%	299	7.8%
SUBTOTAL	29.0%	2,457	10.6%	2,536	3.2%	2,743	8.2%	2,979	8.6%	3,235	8.6%	3,503	8.3%	3,777	7.8%	4,072	7.8%
o HOSPICE																	
- Aged	NA	60	81.8%	85	41.7%	114	34.1%	152	33.3%	199	30.9%	256	28.6%	323	26.2%	408	26.2%
- Disabled	NA	3	50.0%	5	66.7%	6	20.0%	8	33.3%	11	37.5%	14	27.3%	17	21.4%	21	21.4%
SUBTOTAL	NA	63	80.0%	90	42.9%	120	33.3%	160	33.3%	210	31.3%	270	28.6%	340	25.9%	428	25.9%
TOTAL BENEFITS	16.0%	49,804	1.9%	52,040	4.5%	55,750	7.1%	62,305	11.8%	68,764	10.4%	75,359	9.6%	81,943	8.7%	89,102	8.7%

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TABLE A5 - ASSUMPTIONS FOR HOSPITAL INSURANCE PROJECTIONS

	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89	FY 1991	% CHANGE FROM '90	FY 1992	% CHANGE FROM '91	FY 1993	% CHANGE FROM '92	FY 1994	% CHANGE FROM '93
INPATIENT HOSPITAL																
o ADMISSIONS (in thousands)																
- Previous Estimate	10,556	-0.8%	10,714	1.5%	11,039	3.0%	11,427	3.5%	11,827	3.5%	12,212	3.3%	12,589	3.1%	12,978	3.1%
- Current Estimate	10,557	-0.8%	10,735	1.7%	11,092	3.3%	11,505	3.7%	11,919	3.6%	12,314	3.3%	12,698	3.1%	13,094	3.1%
CHANGE	1		21		53		78		92		102		109		116	
o BENEFITS/ADMISSION																
- Previous Estimate	4,490	5.4%	4,581	2.0%	4,718	3.0%	5,079	7.7%	5,379	5.9%	5,677	5.5%	5,972	5.2%	6,282	5.2%
- Current Estimate	4,490	5.4%	4,622	2.9%	4,764	3.1%	5,146	8.0%	5,471	6.3%	5,786	5.8%	6,096	5.4%	6,423	5.4%
CHANGE	0		41		46		67		92		109		124		141	
SNF DAYS/ENROLLEE																
- Previous Estimate	0.268	-11.0%	0.269	0.4%	0.270	0.4%	0.271	0.4%	0.272	0.4%	0.274	0.7%	0.276	0.7%	0.278	0.7%
- Current Estimate	0.268	-11.0%	0.270	0.7%	0.270	0.0%	0.272	0.7%	0.273	0.4%	0.275	0.7%	0.277	0.7%	0.279	0.7%
CHANGE	0.000		0.001		0.000		0.001		0.001		0.001		0.001		0.001	
o SNF BENEFITS/DAY																
- Previous Estimate	$71	6.0%	$74	4.2%	$79	6.8%	$84	6.3%	$89	6.0%	$94	5.6%	$99	5.3%	$104	5.1%
- Current Estimate	$71	6.0%	$74	4.2%	$79	6.8%	$83	5.1%	$88	6.0%	$93	5.7%	$98	5.4%	$103	5.1%
CHANGE	0.000		0.000		0.000		-1.000		-1.000		-1.000		-1.000		-1.000	
HHA VISITS/ENROLLEE																
- Previous Estimate	1.306	-12.1%	1.310	0.3%	1.315	0.4%	1.321	0.5%	1.328	0.5%	1.337	0.7%	1.345	0.6%	1.353	0.6%
- Current Estimate	1.308	-11.9%	1.313	0.4%	1.318	0.4%	1.325	0.5%	1.334	0.7%	1.344	0.7%	1.354	0.7%	1.364	0.7%
CHANGE	0.002		0.003		0.003		0.004		0.006		0.007		0.009		0.011	
o HHA BENEFITS/VISIT																
- Previous Estimate	$60	3.4%	$62	3.3%	$66	6.5%	$70	6.1%	$74	5.7%	$78	5.4%	$82	5.1%	$86	4.9%
- Current Estimate	$60	3.4%	$62	3.3%	$66	6.5%	$70	6.1%	$74	5.7%	$78	5.4%	$82	5.1%	$86	4.9%
CHANGE	0.000		0.000		0.000		0.000		0.000		0.000		0.000		0.000	

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FY 1990 DEPARTMENTAL SUBMISSION

	1988	1989	1990	1991	1992	1993	1994
HOSPITAL MARKET BASKET							
- Previous Estimate	4.2%	4.6%	5.0%	5.0%	4.8%	4.4%	
- Current Estimate	4.2%	4.6%	5.0%	5.0%	4.8%	4.4%	4.6%
CHANGE	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
CASE MIX CHANGES (Used)							
- Previous Estimate	1.0%	0.5%	0.5%	0.5%	0.5%	0.5%	
- Current Estimate	2.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
CASE MIX CHANGES (Total)							
- Previous Estimate	1.0%	0.5%	0.5%	0.5%	0.5%	0.5%	
- Current Estimate	2.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
CHANGE	1.0%	0.5%	0.5%	0.5%	0.5%	0.5%	
TOTAL ENROLLEES (THOUSANDS)							
- Previous Estimate	31,820	32,428	33,016	33,580	34,127	34,661	
- Current Estimate	31,886	32,576	33,228	33,822	34,390	34,940	35,504
PERCENT CHANGE	0.2%	0.5%	0.6%	0.7%	0.8%	0.8%	
TOTAL ENROLLEES RECEIVING BENEFITS (THOUSANDS)							
- Previous Estimate	7,295	7,500	7,735	7,975	8,195	8,415	
- Current Estimate	7,305	7,540	7,790	8,040	8,265	8,495	8,731
PERCENT CHANGE	0.1%	0.5%	0.7%	0.8%	0.9%	1.0%	
AVERAGE LENGTH OF STAY (DAYS)							
- Previous Estimate	9.0	9.0	9.0	9.0	9.0	9.0	
- Current Estimate	9.0	9.0	9.0	9.0	9.0	9.0	9.0
PERCENT CHANGE	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
BENEFITS PER ENROLLEE							
- Previous Estimate	1,618	1,684	1,841	1,988	2,137	2,283	
- Current Estimate	1,632	1,711	1,875	2,033	2,191	2,345	2,510
PERCENT CHANGE	0.9%	1.6%	1.9%	2.3%	2.5%	2.7%	

Supplementary Medical Insurance

Benefits for the Supplementary Medical Insurance program (SMI) for FY 1990 are projected to be $43.7 billion. This represents a $5.2 billion increase over FY 1989 or a 13.5 percent increase. Expenditure growth in SMI program benefits is a result of an increasing intensity and utilization of SMI services.

The following list details the increase for FY 1990 as distributed among the various services covered under the SMI program:

- total physician services are projected to be $30.4 billion, an increase of 11.4 percent over FY 1989;
- outpatient services will be $9.5 billion, an increase of 18.0 percent;
- group practice will be $2.3 billion, up 18.0 percent;
- independent lab services will total $1.4 billion, an increase of 22.2 percent; and
- home health services will be 51 million, up 13.3 percent from the previous year.

The number of SMI enrollees is projected to be 32.9 million; consisting of 29.9 million aged and 3.0 million disabled beneficiaries in FY 1990. This represents a growth in Part B enrollment of 2.1 percent over FY 1989. Enrollment by 1993 is expected to grow at marginally lower rates than in FY 1990. The percent of enrollees receiving benefits appears to have stabilized at near 78.6 percent. This percentage may change in FY 1990 and beyond as a result of catastrophic health insurance.

The average amount of benefits per enrollee is projected to be $1,313 for the aged, $1310 for the disabled non-ESRD and $13,638 for ESRD enrollees. Benefits per enrollee receiving services will increase by 11.6 percent for aged and 7.9 percent for disabled in FY 1990.

Based on economic assumptions used during the FY 1989 President's Budget, the current law projections show the rate of program increase to be 13.5 percent in FY 1990 and to grow at an average rate of 14.3 percent through FY 1993. Benefits will reach $65.3 billion by FY 1993 which is 49.3 percent higher than FY 1990. The increase in the outyears will still be driven primarily by increases in physician fees, utilization, and a continued shift from inpatient to ambulatory settings.

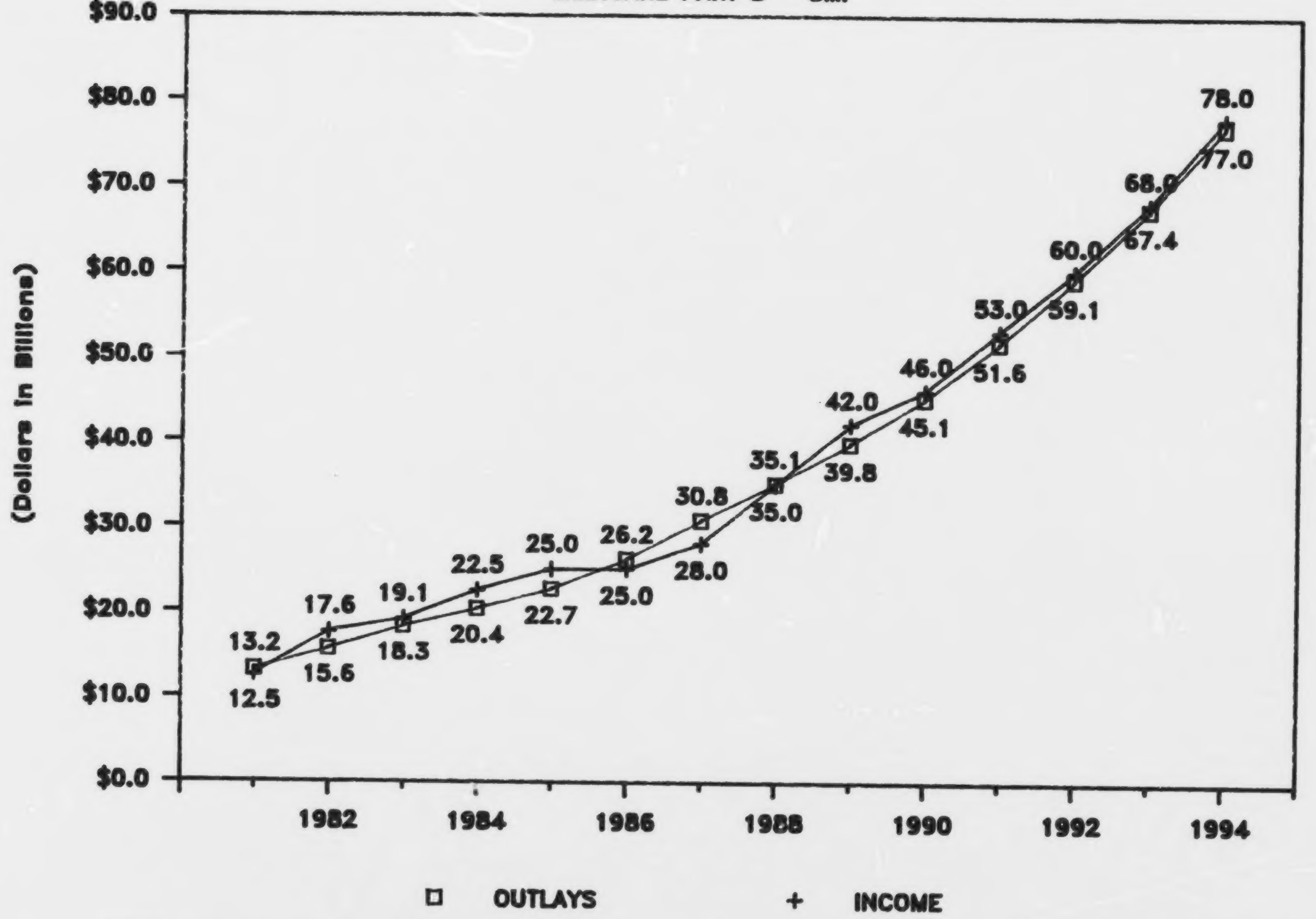
The financing of the Part B (SMI) trust fund is on a year-to-year basis through the annual promulgation of the adequate rate. As a voluntary enrollment program, a premium is paid by enrollees covering 25 percent of the program cost through 1989, while the remaining portion is provided by the Federal government. Under current law, after 1989, the premium will be limited to the percentage of the SSA COLA update. The trust fund is required by law to be sufficient to finance all current liabilities plus a contingency margin (up to 5%) to cover estimating error.

The tables present current law estimates. However, in FY 1990 we propose $0.8 billion in savings resulting from new proposals and a one year delay in the legislative proposals contained in the FY 1989 President's Budget. For the FY 1990 to FY 1994 period, these savings would total $9.9 billion.

In addition, our proposals include additional income from premiums of $630 million for FY 1990. For the FY 1990 to FY 1994 period, this proposed premium income would total $13.7 billion. The premium proposal reflects a higher FY 1990 savings created by the difference in the current law's COLA only increase and the maintenance of 25 percent in FY 1990 and the outyears.

HEALTH CARE FINANCING ADMINISTRATION

MEDICARE PART B – SMI



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HEALTH CARE FINANCING ADMINISTRATION

FEDERAL SUPPLEMENTAL MEDICAL INSURANCE - PART B

SOURCES OF OUTLAYS

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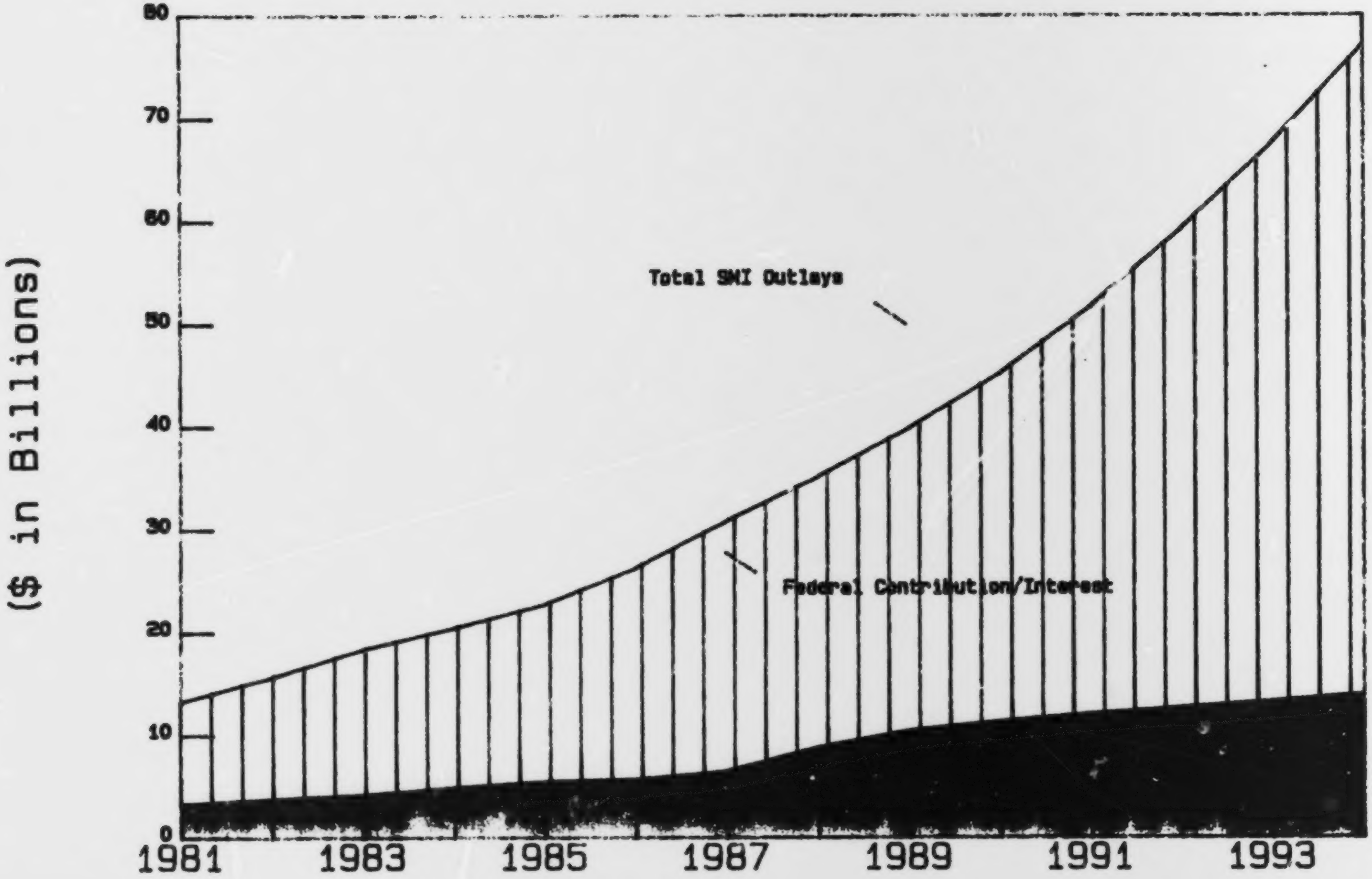
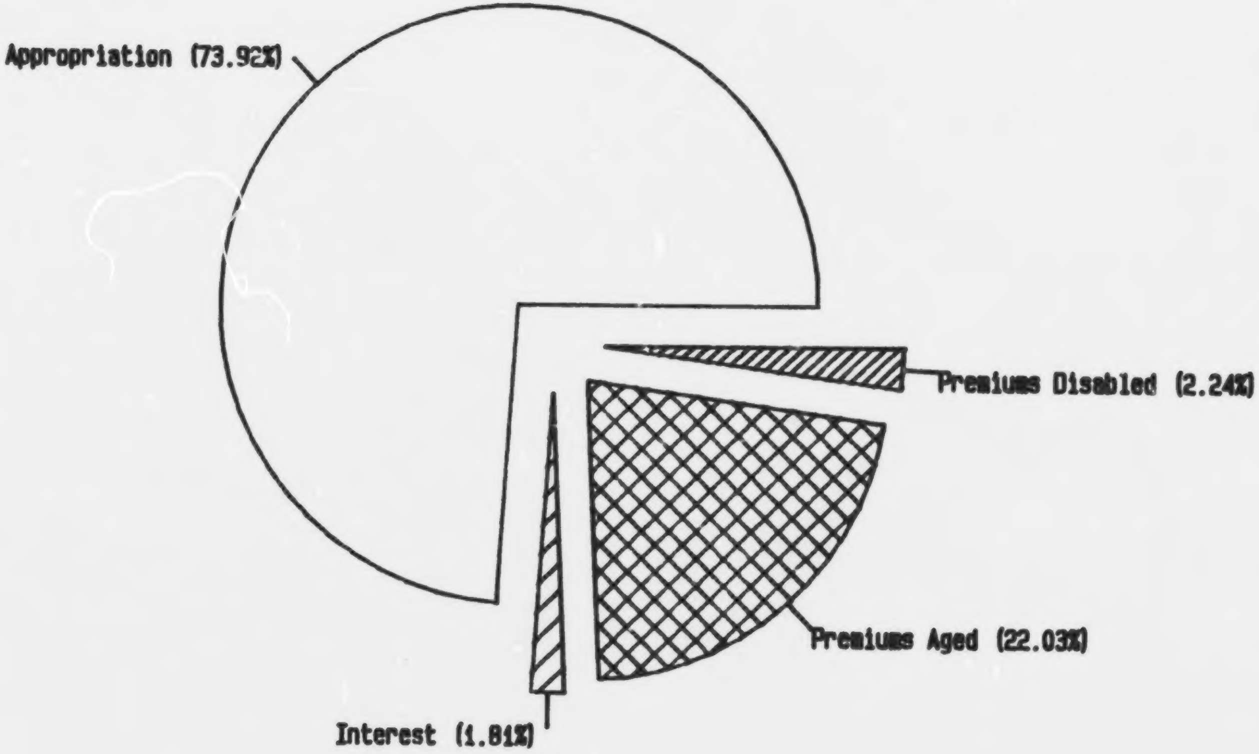


SMI INCOME BY SOURCE

FY 1990 INCOME $46, 452



(Dollars in Millions)

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SMI BENEFIT OUTLAYS BY TYPE OF SERVICE
TOTAL FY 1990 BENEFIT OUTLAYS $43,715

(in millions)

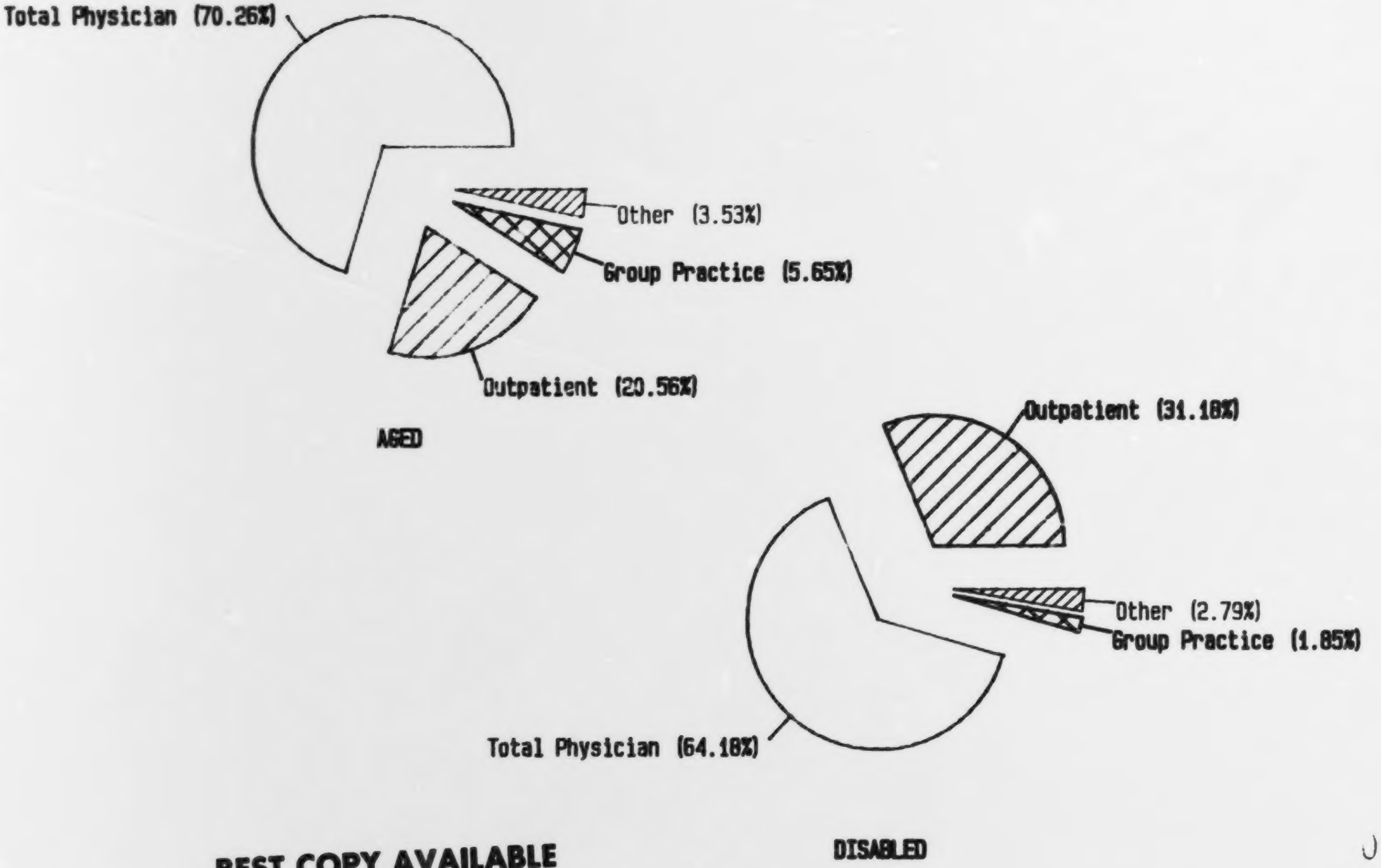

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TABLE B1 - HISTORICAL MEDICARE PART B OUTLAYS BY SERVICE
(DOLLARS IN MILLIONS)

	FY 1967	FY 1968	FY 1969	FY 1970	FY 1971	FY 1972	FY 1973	FY 1974	FY 1975	FY 1976	TQ 1976	FY 1977	FY 1978	FY 1979	FY 1980
PHYSICIAN	627	1,292	1,462	1,581	1,695	1,868	1,972	2,266	2,874	3,438	897	4,286	4,953	5,948	7,283
% CHANGE		106.1%	13.2%	8.1%	7.2%	10.2%	5.6%	14.9%	26.8%	19.6%	N/A	N/A	15.6%	20.1%	22.4%
RADIOLOGY AND PATHOLOGY	2	12	54	233	136	128	147	161	193	251	71	313	373	449	531
% CHANGE		500.0%	350.0%	331.5%	-41.6%	-5.9%	14.8%	9.5%	19.9%	30.1%	N/A	N/A	19.2%	20.4%	18.3%
TOTAL PHYSICIAN	629	1,304	1,516	1,814	1,831	1,996	2,119	2,427	3,067	3,689	968	4,599	5,326	6,397	7,814
% CHANGE		107.3%	16.3%	19.7%	0.9%	9.0%	6.2%	14.5%	26.4%	20.3%	N/A	N/A	15.8%	20.1%	22.2%
OUTPATIENT	10	32	67	93	118	162	180	321	530	745	237	988	1,230	1,496	1,847
% CHANGE		220.0%	109.4%	38.8%	26.9%	37.3%	11.1%	78.3%	65.1%	40.6%	N/A	N/A	24.5%	21.6%	23.5%
GROUP PRACTICE	14	22	26	26	26	32	36	49	62	99	23	104	90	122	190
% CHANGE		57.1%	18.2%	0.0%	0.0%	23.1%	12.5%	36.1%	26.5%	59.7%	N/A	N/A	-13.5%	35.6%	55.7%
INDEPENDENT LAB	3	8	7	11	11	15	18	20	32	44	13	59	69	89	106
% CHANGE		166.7%	-12.5%	57.1%	0.0%	36.4%	20.0%	11.1%	60.0%	37.5%	N/A	N/A	16.9%	29.0%	19.1%
HOME HEALTH	8	24	29	35	49	50	38	57	74	95	28	117	137	155	187
% CHANGE		200.0%	20.8%	20.7%	40.0%	2.0%	-24.0%	50.0%	29.8%	28.4%	N/A	N/A	17.1%	13.1%	20.6%
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TOTAL BENEFITS	664	1,390	1,645	1,979	2,035	2,255	2,391	2,874	3,765	4,672	1,269	5,867	6,852	8,259	10,144
% CHANGE		109.3%	18.3%	20.3%	2.8%	10.8%	6.0%	20.2%	31.0%	24.1%	20.8%	20.2%	16.8%	20.5%	22.8%

	FY 1981	FY 1982	FY 1983	FY 1984	FY 1985	FY 1986	FY1987	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
PHYSICIAN	8,860	10,649	12,890	14,582	16,224	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
% CHANGE	21.7%	20.2%	21.0%	13.1%	11.3%									
RADIOLOGY AND PATHOLOGY	654	743	609	615	565	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
% CHANGE	23.2%	13.6%	-18.0%	1.0%	-8.1%									
TOTAL PHYSICIAN	9,514	11,392	13,499	15,197	16,789	18,553	21,915	24,588	27,320	30,442	34,124	38,402	42,998	48,049
% CHANGE	21.8%	19.7%	18.5%	12.6%	10.5%	10.5%	18.1%	12.2%	11.1%	11.4%	12.1%	12.5%	12.0%	11.7%
OUTPATIENT	2,248	2,916	3,346	3,533	3,903	4,925	5,793	6,755	8,026	9,473	11,261	13,411	15,972	19,040
% CHANGE	21.7%	29.7%	14.7%	5.6%	10.5%	26.2%	17.6%	16.6%	18.8%	18.0%	18.9%	19.1%	19.1%	19.2%
GROUP PRACTICE	243	308	411	465	571	953	1,336	1,624	1,950	2,301	2,705	3,175	3,722	4,363
% CHANGE	27.9%	26.7%	33.4%	13.1%	22.8%	66.9%	40.2%	21.6%	20.1%	18.0%	17.6%	17.4%	17.2%	17.2%
INDEPENDENT LAB	141	174	209	253	492	694	853	1,002	1,185	1,448	1,760	2,108	2,504	2,974
% CHANGE	33.0%	23.4%	20.1%	21.1%	94.5%	41.1%	22.9%	17.5%	18.3%	22.2%	21.5%	19.8%	18.8%	18.8%
HOME HEALTH	199	16	22	25	53	44	35	40	45	51	57	63	71	80
% CHANGE	6.4%	-92.0%	37.5%	13.6%	112.0%	-17.0%	-20.5%	14.3%	12.5%	13.3%	11.8%	10.5%	12.7%	12.7%
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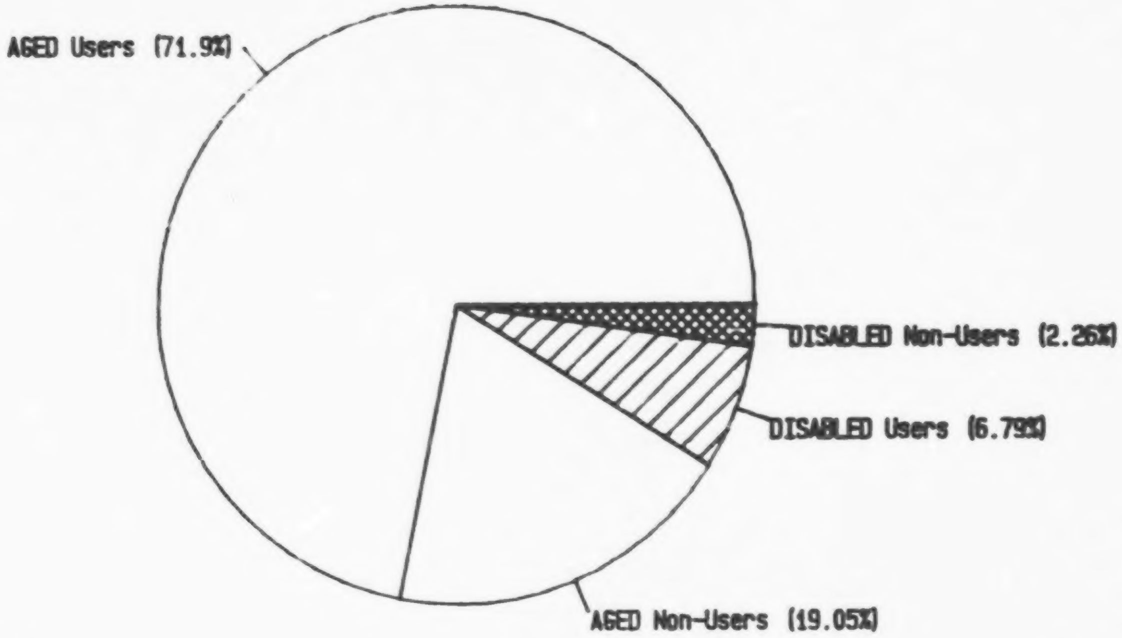
TOTAL BENEFITS	12,345	14,806	17,487	19,473	21,808	25,169	29,932	34,009	38,526	43,715	49,907	57,159	65,267	74,506
% CHANGE	21.7%	19.9%	18.1%	11.4%	12.0%	15.4%	18.9%	13.6%	13.3%	13.5%	14.2%	14.5%	14.2%	14.2%

SMI ENROLLEES

FY 1990 TOTAL 32,864

(in thousands)



AGED Receiving Benefits (Users) 23,591
Disabled Receiving Benefits (Users) 2,229
Total Receiving Benefits 25,820

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TABLE B2 - SMI ENROLLEE DATA
(ENROLLEES IN THOUSANDS)

SMI ENROLLEES	AVE % CHANGE 77-85	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89	FY 1991	% CHANGE FROM '90	FY 1992	% CHANGE FROM '91	FY 1993	% CHANGE FROM '92	FY 1994	% CHANGE FROM '93
o AGED	3.2%	28,154	2.0%	28,716	2.0%	29,275	1.9%	29,842	1.9%	30,337	1.7%	30,816	1.6%	31,278	1.5%	31,747	1.5%
o DISABLED																	
- Disabled	33.2%	2,732	2.6%	2,788	2.0%	2,878	3.2%	2,975	3.4%	3,052	2.6%	3,121	2.3%	3,197	2.4%	3,275	2.4%
- ESRD	NA	39	34.5%	42	7.7%	45	7.1%	47	4.4%	49	4.3%	50	2.0%	52	4.0%	54	3.8%
SUBTOTAL	33.3%	2,771	2.9%	2,830	2.1%	2,923	3.3%	3,022	3.4%	3,101	2.6%	3,171	2.3%	3,249	2.5%	3,329	2.5%
TOTAL ENROLLEES	6.4%	30,925	2.1%	31,546	2.0%	32,198	2.1%	32,864	2.1%	33,438	1.7%	33,987	1.6%	34,527	1.6%	35,076	1.6%
SMI ENROLLEES RECEIVING BENEFITS																	
o AGED	6.0%	22,143	4.8%	22,714	2.6%	23,157	2.0%	23,591	1.9%	23,997	1.7%	24,375	1.6%	24,741	1.5%	25,112	1.5%
o DISABLED																	
- age 21 - 65		2,037	3.3%	2,084	2.3%	2,151	3.2%	2,225	3.4%	2,283	2.6%	2,334	2.2%	2,392	2.5%	2,451	2.5%
- under 21		3	50.0%	3	0.0%	4	33.3%	4	0.0%	4	0.0%	4	0.0%	4	0.0%	4	0.0%
SUBTOTAL DISABLED	6.4%	2,040	3.4%	2,087	2.3%	2,155	3.3%	2,229	3.4%	2,287	2.6%	2,338	2.2%	2,396	2.5%	2,455	2.5%
TOTAL RECEIVING BENEFITS	6.0%	24,183	4.7%	24,801	2.6%	25,312	2.1%	25,820	2.0%	26,284	1.8%	26,713	1.6%	27,137	1.6%	27,567	1.6%
TOTAL AS PERCENT OF ENROLLEES		78.2%		78.6%		78.6%		78.6%		78.6%		78.6%		78.6%		78.6%	

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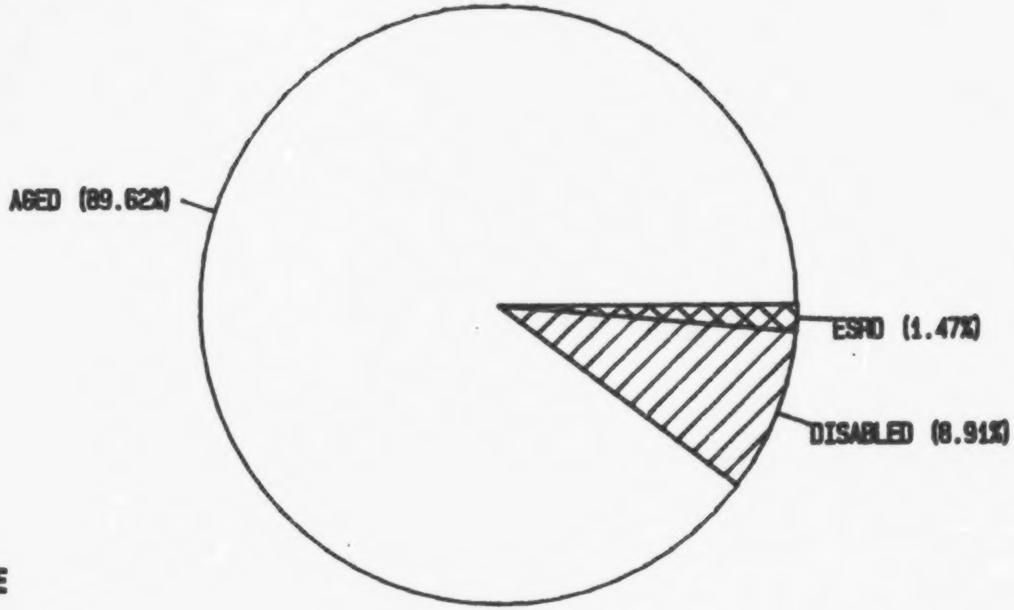
SMI BENEFIT OUTLAYS

Overall Average $1, 330



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BENEFITS BY ENROLLEE GROUP:	Average Benefit Per Enrollee	Number of Enrollees (thousands)	Total Benefits ($ in millions)
Aged	$1,313	29,842	$39,178
Disabled	$1,310	2,975	$3,896
ESRD	$13,638	47	$641
TOTAL:	$1,330	32,864	$43,715

TABLE 83 - SMI BENEFITS BY TYPE OF ENROLLEE

TOTAL BENEFITS PER ENROLLEE CATEGORY (BENEFITS IN MILLIONS)

TYPE OF ENROLLEE	AVE % CHANGE 77-86	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89	FY 1991	% CHANGE FROM '90	FY 1992	% CHANGE FROM '91	FY 1993	% CHANGE FROM '92	FY 1994	% CHANGE FROM '93
o AGED	20.4%	26,350	19.4%	30,327	15.1%	34,460	13.6%	39,178	13.7%	44,813	14.4%	51,403	14.7%	58,778	14.3%	67,191	14.3%
o DISABLED																	
- Disabled	19.8%	3,044	13.3%	3,129	2.8%	3,468	10.8%	3,896	12.3%	4,403	13.0%	5,011	13.8%	5,690	13.6%	6,461	13.6%
- ESRD	7.7%	543	31.5%	553	1.8%	598	8.1%	641	7.2%	691	7.8%	745	7.8%	799	7.2%	857	7.3%
SUBTOTAL	17.3%	3,587	15.7%	3,682	2.6%	4,066	10.4%	4,537	11.6%	5,094	12.3%	5,756	13.0%	6,489	12.7%	7,315	12.7%
TOTAL BENEFITS	20.0%	29,937	18.9%	34,009	13.6%	38,526	13.3%	43,715	13.5%	49,907	14.2%	57,159	14.5%	65,267	14.2%	74,506	14.2%

BENEFITS PER ENROLLEE (BENEFITS IN DOLLARS)

TYPE OF ENROLLEE	AVE % CHANGE 77-86	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89	FY 1991	% CHANGE FROM '90	FY 1992	% CHANGE FROM '91	FY 1993	% CHANGE FROM '92	FY 1994	% CHANGE FROM '93
o AGED	17.5%	936	17.1%	1,056	12.8%	1,177	11.5%	1,313	11.5%	1,477	12.5%	1,668	12.9%	1,879	12.7%	2,116	12.6%
o DISABLED																	
- Disabled	17.6%	1,114	10.5%	1,122	0.7%	1,205	7.4%	1,310	8.7%	1,443	10.2%	1,606	11.3%	1,780	10.9%	1,973	10.8%
- ESRD	2.8%	13,923	-2.2%	13,167	-5.4%	13,289	0.9%	13,638	2.6%	14,102	3.4%	14,900	5.7%	15,365	3.1%	15,870	3.3%
SUBTOTAL DISABLED	15.1%	1,294	12.4%	1,301	0.5%	1,391	6.9%	1,501	7.9%	1,643	9.4%	1,815	10.5%	1,997	10.0%	2,197	10.0%
TOTAL BENEFITS	17.1%	968	16.5%	1,078	11.4%	1,197	11.0%	1,330	11.2%	1,493	12.2%	1,682	12.7%	1,890	12.4%	2,124	12.4%

BENEFITS PER ENROLLEE RECEIVING BENEFITS (BENEFITS IN DOLLARS)

TYPE OF ENROLLEE	AVE % CHANGE 77-86	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89	FY 1991	% CHANGE FROM '90	FY 1992	% CHANGE FROM '91	FY 1993	% CHANGE FROM '92	FY 1994	% CHANGE FROM '93
o AGED	13.6%	1,190	13.9%	1,335	12.2%	1,488	11.5%	1,661	11.6%	1,867	12.4%	2,109	12.9%	2,376	12.7%	2,676	12.6%
o DISABLED	10.3%	1,758	11.9%	1,764	0.3%	1,887	6.9%	2,035	7.9%	2,227	9.4%	2,462	10.5%	2,708	10.0%	2,980	10.0%
TOTAL BENEFITS	13.1%	1,238	13.6%	1,371	10.8%	1,522	11.0%	1,693	11.2%	1,887	12.1%	2,140	12.7%	2,405	12.4%	2,703	12.4%

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TABLE B4 - SMI BENEFITS BY TYPE OF SERVICE
(BENEFITS IN MILLIONS)

	AVE % CHANGE 77-85	FY 1987	% CHANGE FROM '86	FY 1988	% CHANGE FROM '87	FY 1989	% CHANGE FROM '88	FY 1990	% CHANGE FROM '89	FY 1991	% CHANGE FROM '90	FY 1992	% CHANGE FROM '91	FY 1993	% CHANGE FROM '92	FY 1994	% CHANGE FROM '93
TOTAL PHYSICIAN																	
- Aged	19.0%	19,754	18.5%	22,277	12.8%	24,737	11.0%	27,530	11.3%	30,823	12.0%	34,639	12.4%	38,724	11.8%	43,195	11.5%
- Disabled	19.3%	2,161	15.1%	2,311	6.9%	2,583	11.8%	2,912	12.7%	3,301	13.4%	3,763	14.0%	4,274	13.6%	4,854	13.6%
SUBTOTAL	19.0%	21,915	18.1%	24,588	12.2%	27,320	11.1%	30,442	11.4%	34,124	12.1%	38,402	12.5%	42,998	12.0%	48,049	11.7%
o OUTPATIENT																	
- Aged	26.0%	4,585	18.4%	5,532	20.7%	6,717	21.4%	8,058	20.0%	9,721	20.6%	11,722	20.6%	14,120	20.5%	17,009	20.5%
- Disabled	13.6%	1,208	14.8%	1,223	1.2%	1,309	7.0%	1,415	8.1%	1,540	8.8%	1,689	9.7%	1,852	9.7%	2,031	9.7%
SUBTOTAL	22.2%	5,793	17.6%	6,755	16.6%	8,026	18.8%	9,473	18.0%	11,261	18.9%	13,411	19.1%	15,972	19.1%	19,040	19.2%
o GROUP PRACTICE																	
- Aged	31.8%	1,204	40.7%	1,566	30.1%	1,880	20.1%	2,217	17.9%	2,606	17.5%	3,058	17.3%	3,583	17.2%	4,198	17.2%
- Disabled	32.8%	132	36.1%	58	-56.1%	70	20.7%	84	20.0%	99	17.9%	117	18.2%	139	18.8%	165	18.7%
SUBTOTAL	31.9%	1,336	40.2%	1,624	21.6%	1,950	20.1%	2,301	18.0%	2,705	17.6%	3,175	17.4%	3,722	17.2%	4,363	17.2%
o INDEPENDENT LAB																	
- Aged	36.0%	767	23.3%	912	18.9%	1,081	18.5%	1,322	22.3%	1,606	21.5%	1,921	19.6%	2,280	18.7%	2,706	18.7%
- Disabled	36.4%	86	19.4%	90	4.7%	104	15.6%	126	21.2%	154	22.2%	187	21.4%	224	19.8%	268	19.6%
SUBTOTAL	36.1%	853	22.9%	1,002	17.5%	1,185	18.3%	1,448	22.2%	1,760	21.5%	2,108	19.8%	2,504	18.8%	2,974	18.8%
o HOME HEALTH																	
- Aged	-10.5%	35	-20.5%	40	14.3%	45	12.5%	51	13.3%	57	11.8%	63	10.5%	71	12.7%	80	12.7%
- Disabled	-100.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
SUBTOTAL	-11.5%	35	-20.5%	40	14.3%	45	12.5%	51	13.3%	57	11.8%	63	10.5%	71	12.7%	80	12.7%
TOTAL BENEFITS	20.0%	29,932	18.9%	34,009	13.6%	38,526	13.3%	43,715	13.5%	49,907	14.2%	57,159	14.5%	65,267	14.2%	74,506	14.2%

TABLE B5 - ASSUMPTIONS FOR SUPPLEMENTARY MEDICAL INSURANCE PROJECTION

	1986	1987	1988	1989	1990	1991	1992	1993	1994
ECONOMIC INDEX									
- Previous Estimate	4.15%	3.20%	3.60%	3.00%	4.80%	4.60%	4.00%	3.80%	
- Current Estimate	4.15%	3.20%	3.60%	3.00%	4.80%	4.60%	4.00%	3.80%	
CHANGE	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	
	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
PHYSICIAN FEES (AGED)									
- Previous Estimate	2.1%	4.3%	3.2%	2.8%	3.7%	4.8%	5.2%	4.6%	
- Current Estimate	2.1%	4.4%	3.2%	2.7%	3.8%	4.8%	5.3%	4.6%	
CHANGE	0.0%	0.1%	0.0%	-0.1%	0.1%	0.0%	0.1%	0.0%	
PHYSICIAN FEES (DISABLED)									
- Previous Estimate	2.1%	4.2%	3.3%	2.7%	3.7%	4.8%	5.2%	4.5%	
- Current Estimate	2.1%	4.3%	3.2%	2.8%	3.8%	4.8%	5.3%	4.6%	
CHANGE	0.0%	0.1%	-0.1%	0.1%	0.1%	0.0%	0.1%	0.1%	
PHYSICIAN RESIDUAL (AGED)									
- Previous Estimate	10.5%	8.7%	6.1%	5.8%	4.9%	4.7%	4.8%	4.8%	
- Current Estimate	10.5%	8.6%	5.9%	5.4%	4.7%	4.7%	4.7%	4.8%	
CHANGE	0.0%	-0.1%	-0.2%	-0.4%	-0.2%	0.0%	-0.1%	0.0%	
PHYSICIAN RESIDUAL (DISABLED)									
- Previous Estimate	10.7%	8.0%	3.7%	5.8%	5.3%	5.6%	6.1%	6.1%	
- Current Estimate	10.7%	7.9%	3.5%	5.3%	5.1%	5.6%	6.0%	6.0%	
CHANGE	0.0%	-0.1%	-0.2%	-0.5%	-0.2%	0.0%	-0.1%	-0.1%	
OUTPATIENT (AGED)									
- Previous Estimate	27.1%	21.4%	17.8%	15.7%	17.3%	17.9%	18.1%	18.1%	
- Current Estimate	27.1%	21.3%	17.2%	15.3%	17.4%	18.0%	18.1%	18.2%	
CHANGE	0.0%	-0.1%	-0.6%	-0.4%	0.1%	0.1%	0.0%	0.1%	
ENROLLEES (THOUSANDS)									
- Previous Estimate		30,934	31,576	32,183	32,773	33,330	33,859	34,384	
- Current Estimate		30,925	31,546	32,198	32,864	33,438	33,987	34,527	35,076
PERCENT CHANGE		0.0%	-0.1%	0.0%	0.3%	0.3%	0.4%	0.4%	
BENEFITS PER ENROLLEE									
- Previous Estimate		968	1,080	1,203	1,341	1,504	1,694	1,904	
- Current Estimate		965	1,078	1,197	1,330	1,493	1,682	1,890	2,124
PERCENT CHANGE		0.0%	-0.2%	-0.5%	-0.8%	-0.8%	-0.7%	-0.7%	

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FY 1990 DEPARTMENTAL SUBMISSION

	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990	FY 1991	FY 1992	FY 1993	FY 1994
OUTPATIENT (DISABLED)									
- Previous Estimate	28.5%	12.3%	6.8%	6.5%	9.4%	10.7%	12.1%	12.0%	
- Current Estimate	28.5%	12.2%	6.3%	5.8%	9.2%	10.8%	12.2%	12.0%	
CHANGE	0.0%	-0.1%	-0.5%	-0.7%	-0.2%	0.1%	0.1%	0.0%	
HOME HEALTH (AGED)									
- Previous Estimate	10.4%	8.4%	11.6%	10.4%	8.8%	10.4%	10.5%	9.5%	
- Current Estimate	10.4%	8.4%	11.6%	10.4%	8.8%	10.4%	10.5%	9.5%	
CHANGE	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
GROUP PRACTICE (AGED)									
- Previous Estimate	19.8%	33.1%	21.5%	17.7%	14.8%	15.0%	15.0%	15.0%	
- Current Estimate	19.8%	33.1%	21.6%	17.7%	14.8%	15.0%	15.0%	15.0%	
CHANGE	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	
GROUP PRACTICE (DISABLED)									
- Previous Estimate	27.9%	33.2%	20.9%	18.2%	14.5%	14.8%	15.4%	15.2%	
- Current Estimate	27.9%	33.3%	20.9%	18.2%	14.5%	14.7%	15.4%	15.2%	
CHANGE	0.0%	0.1%	0.0%	0.0%	0.0%	-0.1%	0.0%	0.0%	
INDEPENDENT LAB (AGED)									
- Previous Estimate	16.2%	23.4%	13.1%	14.5%	20.5%	19.4%	17.4%	16.8%	
- Current Estimate	16.2%	24.0%	15.0%	16.3%	20.5%	19.4%	17.4%	16.8%	
CHANGE	0.0%	0.6%	1.9%	1.8%	0.0%	0.0%	0.0%	0.0%	
INDEPENDENT LAB (DISABLED)									
- Previous Estimate	17.5%	16.8%	-5.8%	13.8%	33.7%	29.5%	20.0%	18.4%	
- Current Estimate	17.5%	22.3%	9.7%	14.3%	21.2%	20.9%	20.0%	18.4%	
CHANGE	0.0%	5.5%	15.5%	0.5%	-12.5%	-8.6%	0.0%	0.0%	
ENROLLEES RECEIVING BENEFITS (THOUSANDS)									
- Previous Estimate		24,190	24,827	25,305	25,770	26,209	26,624	27,037	
- Current Estimate		24,183	24,801	25,312	25,820	26,284	26,713	27,137	27,567
PERCENT CHANGE		0.0%	-0.1%	0.0%	0.2%	0.3%	0.3%	0.4%	
BENEFITS PER ENROLLEE RECEIVING BENEFITS									
- Previous Estimate		1,237	1,374	1,531	1,705	1,913	2,155	2,422	
- Current Estimate		1,238	1,371	1,522	1,693	1,899	2,140	2,405	2,703
PERCENT CHANGE		0.1%	-0.2%	-0.6%	-0.7%	-0.7%	-0.7%	-0.7%	

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PEER REVIEW ORGANIZATIONS

FY 1990
PEER REVIEW ORGANIZATIONS

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Attachments

Attachment I - Samplings and Levels of Review for PRO Scope of Work
Attachment IA - Summary of Activities for HCFA Review of HMOs
Attachment II - Assumptions Used to Develop Budget Estimates for Third Scope of Work
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Decision Unit - Peer Review Organizations

ANALYSIS OF RESOURCES
(Dollars in Thousands)

Total Program Level:	FY 1988	FY 1989	FY 1990	FY 1991
Obligations	$377,438 1/	$630,420 3/	$254,478	$303,714
Outlays	$189,701 2/	$321,404	$305,914	$352,243

Total Program Level:	FY 1992	FY 1993	FY 1994
Obligations	$608,531	$300,531	$356,633
Outlays	$381,043	$367,419	$416,754

1/ Obligations for FY 1988 include (in $000s) second round contracts of $35,163, OBRA 87 modifications of $804, third round contracts of $252,915, and extensions of second round contracts of $88,556.

2/ Outlays for FY 1988 include (in $000s) first round expenditures of $2,668 and $137,284 from pre-1988 second round obligations.

3/ Obligations for FY 1989 include (in $000s) third round contracts of $511,869, extensions of second round contracts of $107,093, pilot studies of $11,033, and funds for PROs to collect data necessary for preparation of a report to Congress on implementation of the 100% review/second opinion program (OBRA 86 Section 9401) of $425.

PEER REVIEW ORGANIZATIONS

AUTHORIZING LEGISLATION

Title XI, Part B, and Title XVIII, Section 1866, Social Security Act, as amended by the Social Security Amendments of 1983 (P.L. 98-21), the Deficit Reduction Act of 1984 (P.L. 98-369), the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (P.L. 99-272), the Omnibus Budget Reconciliation Act of 1986 (OBRA 86) (P.L. 99-509) and the Omnibus Budget Reconciliation Act of 1987 (OBRA 87) (P.L. 100-203).

PURPOSE AND FUNCTIONS OF PEER REVIEW ORGANIZATIONS

The Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (P.L. 97-248) provided in Section 141 (the Peer Review Improvement Act of 1982), that the Health Care Financing Administration (HCFA) contract with private utilization and quality control Peer Review Organizations (PRO) to determine the medical necessity, appropriateness and quality of Medicare inpatient hospital services. A hospital, to be paid under Medicare, is required to maintain an agreement with a PRO regarding the review of services furnished to Medicare beneficiaries.

The legislation further prescribed that costs supporting the PRO program "shall be transferred in appropriate proportions from the Federal Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund, without regard to amounts appropriated in advance in appropriation Acts, in the same manner as transfers are made for payment for services provided directly to beneficiaries." Consequently, the PRO program is financed directly from the Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) Trust Funds, and not through an annual appropriation. The Office of Management and Budget apportions funds to HCFA for PRO activities.

The Social Security Act, Section 1153 (as amended), requires the Secretary to enter into contracts with utilization and quality control organizations for the review of services rendered by physicians and other providers of health care services and of items for which payment may be made under the Medicare program. These were 2-year contracts. However, OBRA 87 changed the contract period to 3 years, beginning with the third round of contracts in FY 1989.

Section 602(f) of the Social Security Amendments of 1983 requires that hospitals receiving payments under subsections (c) or (d) of Section 1886 maintain an agreement with a PRO under which the PRO will review the validity of diagnostic information provided by such hospitals; the completeness, adequacy and quality of care provided; the appropriateness of admissions and discharges; and the appropriateness of care for which additional payments are sought under Section 1886(d)(5) (day and cost outliers).

Recent legislation imposed a number of new functions and workloads on the PROs. The following sections describe the key provisions of COBRA, OBRA 86, and OBRA 87.

CONSOLIDATED BUDGET RECONCILIATION ACT OF 1985

Section 9307 Payment for assistants at surgery for certain cataract operations and other operations.

The PROs implemented this provision in March 1987. It consists of preprocedure review and approval of the use of an assistant at cataract surgical procedures, to determine medical necessity.

Section 9401 100 Percent review of certain surgical procedures/second surgical opinion.

This provision is being implemented through the regulatory process. The Notice of Proposed Rulemaking (NPRM) is in the clearance process. In general, PROs will be required to perform 100 percent preadmission or preprocedure review of at least 10 high-volume surgical procedures. Where the PRO determines a second opinion is necessary, a beneficiary must obtain the second opinion from a qualified physician on a list supplied by the PRO.

Section 9403 Denial of payment for substandard care.

HCFA is also implementing this provision through the regulatory process. The Notice of Proposed Rulemaking is in the clearance process. The regulation gives the PROs the authority to deny Medicare payment for services or care found to be substandard in quality.

OMNIBUS BUDGET RECONCILIATION ACT OF 1986

Section 9304 Coverage of hospitals in Puerto Rico under a DRG prospective payment system.

This section requires the Secretary to include eligible Puerto Rico hospitals in PPS. The Puerto Rico PRO contract has been modified to provide for PPS-type medical review.

Section 9343(d) Review of ambulatory surgery procedures.

This section requires that PRO contracts entered into or renewed after January 1, 1987, be modified to provide for review of surgical procedures performed in ambulatory surgery centers and hospital outpatient areas. The provision was implemented in Pennsylvania on July 1, 1987, and in Massachusetts on March 1, 1988. The other PROs will implement it with the third scope of work.

Section 9351 PRO review of hospital notices of noncoverage.

This provision requires PROs to review all proposed hospital notices of noncoverage when the attending physician does not agree with the hospital. The PRO must communicate its decision to the beneficiary not later than one full working day after it first receives the request. Before making its decision, the PRO must solicit the views of the patient. This change was effective December 1, 1986.

Section 9352 PRO review of early readmissions and intervening care.

This section requires PROs to review readmissions occurring within 31 days of discharge from a previous hospital stay. PROs currently review readmissions occurring within 15 days of discharge. In addition, the PRO is to sample the post-discharge/intervening care to determine if the patient was prematurely discharged from the hospital and if there are quality problems with the intervening care. Beginning January 1, 1989, PROs can review intervening care that was delivered in a physician's office.

Pennsylvania and Massachusetts implemented this provision on July 1, 1987, and March 1, 1988, respectively. The other PROs will implement it with the third scope of work.

Section 9353(a)(2) Review of risk-based HMOs/CMPs.

This section requires review of services provided by risk-based HMOs/CMPs to determine whether those services meet professionally recognized standards of health care and whether they have been provided in an appropriate setting. This provision was implemented in fiscal year 1987.

Section 9353(a)(3) Development of methods for identifying cases of substandard care.

The process of devising methods to identify cases of substandard care is underway. Several PROs are participating in a pilot study which requires to abstract clinical information from patient charts and then compare this information with outcomes of care. In this way, PROs will be able to identify indicators of substandard care.

Section 9353(a)(4) Small-area analysis.

This section requires that at least 12 PROs, using data and data processing assistance supplied by HCFA, review and analyze small-area utilization variations within their geographical areas. This activity will be funded partially under the HCFA administrative budget and partially under the PRO budget. This project should be completed during FY 1989.

Section 9353(b) Requiring consumer representation on PRO boards.

This provision requires each PRO to have a consumer representative on its board and was implemented by all PROs on April 1, 1988.

Section 9353(c) Improving peer review responsiveness to beneficiary complaints.

This section requires PRO review of all written complaints about the quality of services received in any setting which PROs are authorized to review. Before concluding that services do not meet professionally recognized standards of health care, PROs will provide the practitioner or provider concerned with both a notice and an opportunity for discussion and will inform the beneficiary of the disposition of the case. This provision was implemented for complaints received after August 1, 1987.

Section 9353(d) Sharing of information by PROs.

This section specifically requires that PROs share information with accrediting bodies. HCFA issued an NPRM on March 16, 1988, and provided for a 60-day comment period. This provision should be implemented during FY 1988.

Section 9353(e) Funding of additional PRO activities (Memoranda of Agreement with HHAs, SNFs).

This provision was implemented October 1, 1987. Funding for this provision was included in Sections 9352(a) and 9353(a)(2).

OMNIBUS BUDGET RECONCILIATION ACT OF 1987

Section 4091(a)(1) Contract Provisions.

This section provides for extensions of existing PRO contracts for a period not to exceed 24 months so that the Secretary can more efficiently deal with PRO contract renewals. It is effective for renewals occuring on or after enactment, i.e., December 23, 1987. In addition, it also:

(a)(2) Changes the contract period from 2 to 3 years. This provision is effective for new or renewal contracts effective after enactment.

(b)(1) Requires that any new policies or procedures adopted by the Secretary which substantially affect the performance of PRO contract obligations be published in the Federal Register not less than 30 days before the date on which they are to take effect. This provision is effective with date of enactment.

(b)(1) Requires that each PRO is to be furnished "regularly" with a report that documents its performance in relation to that of other PROs. This provision is effective with date of enactment.

(b)(1) Mandates, prior to implementation, negotiation of contract modifications that require a PRO to carry out a review function that is in addition to any function required at the time the contract was entered into or renewed. This provision is effective with date of enactment.

Section 4092 Preference in contracting with in-State organizations.

This provision prohibits the Secretary from renewing PRO contracts with out-of-State organizations without first advertising in the Federal Register and offering in-State organizations an opportunity to submit a proposal. This provision is effective August 1, 1988.

Section 4093 Requiring reasonable notice and opportunity for discussion prior to denial of a claim.

This section requires PROs to allow physicians and providers 20 days to discuss potential denials. Prior to this legislative change, PROs provided physicians and providers varying amounts of time in which to respond to a proposed denial notice. This provision is effective for determinations made on or after April 1, 1988.

Section 4094(a) Peer review norms and education.

This requires that when developing standards, PROs must take into account special problems (e.g., those associated with delivering care in remote rural areas). HCFA will implement this provision through the rulemaking process. There are also the following additional provisions:

(b) During each contract year, the PRO must perform significant onsite review activities, including onsite review at at least 20 percent of the rural hospitals. This provision is effective for contracts entered into or renewed after enactment.

(c)(1)(A) Several times a year, the PRO must offer to provide a physician representative to meet with medical and administrative staff of each hospital. This provision is effective for contracts entered into or renewed after enactment.

(c)(1)(A) At least annually, the PRO must publish and distribute to providers and physicians a report describing its findings with regard to types of cases it has frequently determined to involve inappropriate or unnecessary care. This provision is effective for contracts entered into or renewed after enactment.

(c)(2)(A) The PRO must conduct a survey to determine if enrollees in HMO/CMPs are gaining access to needed services. This provision is effective for contracts entered into or renewed after enactment.

(c)(2)(A) The PRO must make arrangements to ensure (to the extent possible) that initial review of psychiatric and physican rehabilitation services is made by a physician who is trained in those respective disciplines. This provision is effective for contracts entered into or renewed after enactment.

(d) In evaluating PROs, HCFA must emphasize their performance in educating providers and practitioners (especially in rural areas) about the review process and criteria. This provision is effective for contracts as of January 1, 1988.

(e) HCFA will conduct demonstration projects to examine the feasibility of requiring instruction and oversight of rural physicians in lieu of sanctions. This provision is effective for contracts entered into or renewed after enactment.

Section 4095(a)-(d) Preexclusion hearings.

Before the Office of Inspector General (OIG) can exlude a provider or practitioner located in a rural Health Manpower Shortage Area, the provider or practitioner is entitled to a hearing before an Administrative Law Judge. This provision is being implemented by the OIG.

Section 4096(a)and(b) Limitation on beneficiary liability for services disallowed by PROs.

This section provides that a physician may not charge a beneficiary for any services denied by a PRO on the basis of substandard care. In addition, when the provider is found to be liable for the cost of services denied because they are not medically necessary or are custodial in nature, the beneficiary no longer is responsible for any applicable deductible and coinsurance amounts. This provision is effective for services furnished on or after January 1, 1988.

Section 4097(a) Separate funding levels.

This section provides that the total costs of PRO review of inpatient hospital services for a fiscal year shall not be less than the aggregate amount expended in FY 1988 for direct and administrative costs (adjusted for inflation) and for any costs incurred as a result of review functions added in subsequent fiscal years. This provision becomes effective for fiscal years beginning on or after October 1, 1988.

RATIONALE FOR FEDERAL ROLE

The activities of the PROs represent the primary Federal effort in monitoring the quality of care provided to Medicare beneficiaries. These efforts are designed to ensure Medicare beneficiaries receive appropriate and medically necessary services and that Medicare Trust Fund expenditures for such services are appropriate.

RELATIONSHIP TO OTHER MEDICARE CONTRACTORS

The PRO program is closely linked in a number of ways with Medicare fiscal contractors (i.e., Part A intermediaries and Part B carriers). First, there is a need for a well coordinated exchange of data. The Medicare fiscal contractors provide individual PROs with bill and claims data and other information essential to the planning and conduct of quality reviews, and the PRO provides them with data about necessary payment adjustments. Secondly, the Medicare fiscal contractors, in their medical review activity, exercise a role related to that of the PROs. However, there is no duplication of responsibility between PROs and the fiscal contractors.

PROs are responsible for peer review (both utilization and quality) of hospital inpatient and ambulatory services. In addition, PROs review, on a sample basis or based upon complaints, SNF and HHA services. Medicare fiscal contractors are responsible for the medical review of other Part A services (e.g., SNF, HHA) and Part B physician/supplier services (utilization only). PROs often perform preadmission, preprocedure, and prepayment reviews. Fiscal contractors only review services after the fact and often after payment.

In the event a PRO contract is terminated, the fiscal intermediary or another PRO will take over the legislatively mandated requirements until a new PRO contract is awarded.

OBJECTIVES OF PRO CONTRACTING PROCESS

The primary objective of PRO review is to ensure that Medicare beneficiaries receive high quality health care. The secondary objective is to protect the Medicare Trust Funds.

The objectives of each contract negotiation are to ensure (1) that the PRO understands the Scope of Work requirements, (2) that the PRO's intervention plan will be effective in monitoring the quality of care provided to Medicare beneficiaries, and (3) to be certain the Government pays a responsible price for PRO services.

PRO contracts are designed to facilitate the PRO's basic responsibility of modifying physician/provider behavior that does not meet local standards of care, i.e., inappropriate, unnecessary, or substandard. PROs carry out this responsibility through the medical review of a sample of Medicare beneficiary inpatient and outpatient services.

The types of medical review performed for each Scope of Work are summarized in Attachments I and IA. A detailed description of the Scope of Work for the second and third contract periods are described below. As needed, HCFA issues regulations and program instructions to supplement the Scope of Work and implement new policy and legislative changes.

Outcomes of PRO review lead to remedial education, peer counseling, denial of payment for bills or services and, as a last resort, the exclusion (through a sanction imposed by the OIG) of a provider or practitioner from participation in Medicare. These activities serve to assure quality of care and provide financial savings to the Medicare Trust Funds. Denials are issued for utilization problems, e.g., inappropriate admissions, DRG coding errors and circumvention of the PPS. As a result of COBRA, regulations are currently being promulgated that will allow PROs to deny services that are determined to be substandard in quality.

CONTRACTING METHODOLOGY

During the current (second) round of PRO contracts, HCFA is using the firm fixed-price contracting method. In FY 1986 and early FY 1987, we negotiated a fixed dollar amount with each PRO for performance of the second scope of work during the full 2-year contract period. All significant changes to the PROs' workload during this period have been negotiated as contract modifications.

For the third round, we plan to negotiate a modified fixed-price contract with most PROs. HCFA will pay a flat negotiated amount for a PRO's administrative costs, which includes most overhead, for the 3-year life of the contract. In addition, we will negotiate a reimbursement amount for each individual review (that is, a unit price per review). There will be four or five separate unit prices to cover different types of reviews or non-review activities.

For example, we expect to negotiate separate prices for simple, complex, and ambulatory reviews as well as for other activities such as reconsiderations. These unit prices will cover all direct costs of performing a review, such as direct labor (including some overhead such as fringe benefits) and travel, as well as an implicit profit margin. HCFA will pay the PROs based on the number of reviews they perform in each category, with an upper limit specified in the contract.

HCFA will continue to pay certain pass-through costs in the third round. These will include the actual costs of photocopying medical records, developing sanctions cases, and similar activities. We will also pay certain one-time costs, such as development of a new PRO cost accounting system and pilot studies.

Although HCFA will negotiate a price for performing PRO review of CHAMPUS cases in third round contracts, the Department of Defense will reimburse us for these reviews each year, if appropriations permit. If DoD does not receive an appropriation for PRO review in any year of the contract, the PROs will not perform that activity.

SECOND ROUND OF PRO CONTRACTS (FY 1986-1988)

The scope of work for the second round of PRO contracts was intended to maximize return on investment and ensure that potential quality of care problems are identified and appropriate corrective actions are taken on verified quality problems.

HCFA addressed these goals by (1) redesigning PRO activities to eliminate low volume/unproductive reviews (e.g., reducing the random sample from 5 percent to 3 percent), (2) targetting DRG validation on "high risk" cases (e.g., DRG 088), and (3) reducing the review burden on hospitals that had not been problem providers, while focusing more reviews on poorly performing providers (identified through HCFA data, individual case review statistics, etc.).

While the scope of work reduced the number of reviews to be performed, it vastly intensified the quality review process. Every case selected for retrospective review is subjected to the generic quality screens; discharge, admission, and coverage review; and DRG validation. This review intensity requires significantly more time to perform and also requires greater involvement of physicians in the review process. This intensity is mandatory to ensure that Medicare beneficiaries receive only medically necessary care of good quality.

The following objectives are required under the second scope of work:

- Reduce quality problems identified through the application of the generic quality screens.
- Eliminate adverse outcomes (including premature discharges) by focusing on aberrant providers and/or practitioners.
- Eliminate adverse outcomes (including premature discharges) by focusing on specific DRGs.
- Reduce unnecessary admissions and/or procedures by provider and/or practitioner.
- Reduce unnecessary admissions and/or procedures by specific DRG.

Highlights of the second scope of work (excluding any new legislative requirements) are:

- Application of generic quality screens to detect: inadequate discharge planning, the discharge of medically unstable patients, unexpected deaths, nosocomial (i.e., hospital-acquired) infections, unscheduled returns to the operating room or special care units, and trauma suffered in the hospitals (e.g., from falls).
- Monitoring readmissions to PPS hospitals within 15 days of discharge (as compared to a 7-day interval in the first Scope of Work).
- Mandated 15 percent review of discharges from specialty hospitals and continued stays in swing beds.
- Lessening the overall review burden by:
  - Reducing the level of review in good hospitals
  - Reducing random sampling to 3 percent
  - Reducing the number of objectives from 8 to 5
  - Raising the threshold for intensified review from 2.5 percent of cases reviewed (or 3 cases) with errors to 5 percent or 6 cases
  - Reducing the requirement for intensified review from 100 percent during the quarter after problem identification to 50 percent with an increase, if warranted, to 100 percent in the subsequent quarter.

- Conducting a beneficiary outreach program.
- Reviewing pacemaker implants plus four other procedures on a preadmission/preprocedure basis.
- Monitoring hospital-issued notices of noncoverage to ensure that Medicare patients are not inappropriately charged for services which are covered by Medicare and to preclude hospitals from pressuring patients to leave prematurely.

Following are specific types of PRO activities during the second contract cycle:

Medicare Code Editor

These reviews address a small number of cases which would not be adequately represented in a random sample. These cases represent conditions which usually do not require hospitalization or are miscoded. For these reasons, this review yields a high denial/DRG change rate. All such cases are subjected to review.

Hospital Notices of Noncoverage

When the patient or physician disagrees with the hospital notice of noncoverage, the PRO reviews all such cases. In addition, the PRO reviews all cases when the patient becomes liable for the cost of care because he remained in the hospital after notification.

Day and Cost Outliers

Review of day and cost outliers is statutorily mandated. Review levels were set at 50 percent during the second round scope of work.

Transfers

Since transfers between hospitals and PPS-exempt units generate more revenue, these cases are sampled to determine that PPS providers are not prematurely transferring patients to "game" the payment system.

Readmissions Within 15 Days of Related Discharge

In response to a widespread concern that PPS hospitals might discharge patients sooner than they should and readmit patients for conditions that should have been treated during the first admission, these reviews represent a safeguard against such practices. During the first round scope of work, PROs reviewed readmissions occurring within 7 days. The change to review readmissions within 15 days strengthens the quality assurance aspect of readmission review.

Validation of Selected DRGs

The following DRGs were selected for 100 percent review because they represented potential problems with either coding or utilization of services:

- #088 - Chronic Obstructive Pulmonary Disease
- #462 - Rehabilitation
- #468 - Unrelated Operating Procedure

Review of Specialty Hospitals and Exempt Units

Review of specialty hospital discharges and direct admissions from home or one hospital to another hospital's exempt unit were included to eliminate unnecessary admissions and inappropriate length of stays. These cases are sampled at a 15 percent level.

Random Sample

Review is conducted on a 3 percent random sample of discharges selected from bills submitted by each PPS hospital. The results of the random sample review are used to predict to the universe the national impact of peer review and to identify problems.

Objectives

Objectives changed from the first contract period. Objectives now focus on statistical outliers identified by means of a multivariant model which makes allowances for differences in demographic characteristics and causes of admissions.

Community Outreach

This effort was designed to inform beneficiaries about the role and focus of PROs in ensuring beneficiary rights. Certain misconceptions about PPS (e.g., that it "forces" a hospital to discharge patients when the average length of stay for the DRG is reached) are also addressed in the PROs' community outreach efforts.

Sanction Recommendations

PROs investigate cases and, where necessary, submit recommendations to the OIG for sanctions, which are designed to identify and admonish providers and practitioners who fail to provide high quality care to Medicare beneficiaries. However, the purpose of sanctions is not to punish providers or practitioners, but rather to protect both the beneficiaries and the Medicare Trust Funds.

THIRD ROUND OF PRO CONTRACTS (FY 1989-1993)

Before developing the third round scope of work, a thorough zero-based analysis was performed on the second round scope of work. After completion of this analysis, the sample size for many categories of review was reduced or deleted. In addition, new statutory review requirements were added. The scope of work is intended to ensure that utilization is controlled and that the quality of care is of the highest quality.

The new scope of work takes an already intensifed quality review process and adds refinements in an attempt to achieve consistency among PROs. The refinements include a uniform quality intervention plan, refined hospital generic quality screens, and new non-inpatient hospital generic screens. In an attempt to control costs, review of highly weighted DRGs is required and invasive procedure review (e.g., surgical procedures), if applicable, must be performed on every case selected for review for any reason.

The requirement for objectives was changed to reflect a standard operating requirement that PROs set objectives as problems are identified. Thus, the somewhat artificial objective setting process has been deleted.

Highlights of the third round scope of work (excluding new legislative requirements) are:

- o Use of a uniform quality intervention plan that requires PROs to assign severity levels and take appropriate interventions in a consistent manner.
- o Requiring a strengthened beneficiary outreach program.
- o Requiring a physician and provider outreach program.
- o Reviewing all cataract extractions as well as 9 other surgical procedures on a preadmission/preprocedure basis.
- o Reviewing the quality of care rendered to beneficiaries in freestanding cardiac catheterization facilities.
- o Continuing to review the following types of cases:
  - Medicare Code Editor
  - Hospital Notices of Noncoverage
  - Discharges from Specialty Hospitals and Exempt Units
  - Random Sample
  - Assistants at Cataract Surgery

In addition, the third scope of work includes the following existing, modified, and new PRO activities:

Validation of Selected DRGs

The following DRGs were selected for 100 percent review because they represent potential problems with either quality, coding, or utilization of services:

#462	Rehabilitation
#468	Unrelated OR Procedures
#385	Neonates, Died or Transferred
#386	Extreme Immaturity, Neonates
#387	Prematurity with Major Problems (MP)
#388	Prematurity without MP
#389	Full Term Neonate with MP
#390	Neonate with Other Significant Problems
#391	Normal Newborn
#472	Extensive Burns
#474	Tracheostomy
#475	Mechanical Ventilation through Endotracheal Intubation

Day and Cost Outliers

Review of day and cost outliers is statutorily mandated. Review levels are set at 25 percent level.

Transfers

PROs will continue to review these cases, except for transfers from PPS beds to exempt rehabiliation units.

Fiscal Intermediary Referrals

These are cases referred by the fiscal intermediary for PRO review. Basically, there are three kinds of referrals.

- Possible hospital premature discharge identified through the review of SNF records.
- Requests by hospitals to adjust already paid claims to a higher weighted DRG.
- Coverage issues (e.g., surgery that might be cosmetic).

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)

The scope of work for CHAMPUS review is similar to the scope of work for PRO review. This review activity will be funded by CHAMPUS in accordance with the provision of an interagency agreement.

EXTENSIONS OF SECOND ROUND CONTRACTS

Section 4091 of OBRA 87 allows for a one-time extension of PRO contracts for up to 24 months. It also changes the contract period from 2 to 3 years. This provision enables HCFA to gain greater control over the contracting cycle and spread out the administrative workload associated with new contracts.

Accordingly, HCFA will extend second round PRO contracts so that 13 PRO contracts will be renewed on October 1, 1988, 15 PRO contracts will be renewed on April 1, 1989, 13 additional PRO contracts will be renewed on October 1, 1989, and the last 13 PRO contracts will be renewed on April 1, 1990. This will enable HCFA to establish its contracting cycle at 6-month intervals over a 2-year period.

The first phase of the contract extensions will extend the second scope of work for all PROs from the end of their current contract to March 31, 1989 or the beginning of the third round of contracts, whichever is sooner. During this first phase, HCFA will negotiate extensions with 50 PROs. Four PROs will begin their third round contact on October 1, 1988, without any extension period.

Calculation of the budgets for the first extension period was based on the current second round contract expenditures, including all contract modifications through March 31, 1988. This expenditure level was increased by the state and local deflator applied to the number of months extended. An additional 15 percent was added to account for sanctions, fraud and abuse investigations, increased workloads and additional contract modifications which could not have been predicted during second round negotiations.

The second phase of contract extensions will be made to all second round PRO contracts which do not begin the third contract cycle until October 1, 1989, or later. This phase will require PROs to implement the third scope of work as of April 1, 1989. HCFA will negotiate second phase extensions with 26 PROs. We will extend 13 PROs to September 30, 1989, and the other 13 PROs to March 31, 1990. No contracts will be extended beyond March 31, 1990. At that time, all PROs will be in the third contract cycle. This phase of contract extensions was calculated using the same assumptions as the third scope of work.

ASSUMPTIONS USED TO DEVELOP BUDGET ESTIMATES FOR THIRD ROUND CONTRACTS

The budget for the third contract cycle reflects a three-tiered contracting approach. First, a non-recurring start-up cost to implement a new HCFA cost reporting requirement. Second, a fixed price per month to cover administrative activities. Third, a unit cost per review for simple, complex, and ambulatory reviews.

The fixed administrative costs are those expenses for non-review activities which the contractor will incur simply because it is an operating organization and which would be present regardless of the number of reviews that may be performed. Such expenses must be reasonable and must be related to the performance of the scope of work and may include the following:

- Management salaries
- Management fringe benefits
- Physician committees (except quality assurance committee)
- Legal consultants
- Financial consultants
- Data consultants
- Data programming
- Rent
- Non-review travel
- Supplies
- Reproduction and printing (Other than photocopy of medical records)
- Telephone
- Meeting expenses
- Maintenance
- Postage (Other than mailing of medical records)
- Utilities
- Equipment
- Insurance

A simple review is defined as the review of a case where the services were provided in only one setting, and if inpatient, during only one admission. Review of intervening care, objectives, and intensified review will also be considered a simple review. HMO/CMP cases selected for the 3 percent inpatient hospital random sample would normally be classified as simple, as would cases for focused ambulatory review. Readmission/transfer cases which are identified after the first admission has been reviewed will also be considered a simple review. The following types of cases are included:

- Random Sample
- Medicare Code Editor
- Hospital Adjustments
- FI Referrals
- Non-covered Admissions
- Focused DRGs
- Hospital Denial Notices
- Specialty Hospitals
- Intervening Care
- Objectives
- Intensified Review
- HMO/CMP
- Readmission/Transfers (identified after the first admission/transfer has been reviewed

A complex review is defined as the review of a case where the services were provided in more than one setting or involved more than one inpatient admission. Outlier cases and reconsiderations will also be considered complex reviews. HMO/CMP cases selected under the 13 conditions, transfers and readmissions would also be complex, as would cases selected because of death. Readmission/transfer cases in which both admissions are identified and reviewed at the same time would be classified as complex. The following types of cases are included in this category:

- Transfers (both admissions identified at the same time)
- Readmissions (both admissions identified at the same time)
- Outliers
- Reconsideration
- HMO/CMP

An ambulatory review is defined as the review of a case where the services were provided in other than an inpatient hospital setting or involved only one incidence of care. Preadmission review will also be considered an ambulatory review. The following types of cases are included:

- Ambulatory Surgery (does not include HMO ambulatory review)
- Assistants at Cataract Surgery
- Preadmission

In addition, we will pay PROs for non-recurring costs which are attributable to HCFA-initiated projects or studies which are conducted on a one-time, non-recurring basis, such as pilot or special studies. The following pilot studies will be conducted during FY 1988 or 1989:

- Review of Physician's Services (including services rendered in the physician's office)
- 1-2-3 Day Stays
- Deaths Within 14 Days of Discharge
- Post-Hospital Discharge (Intervening Care)
- Deeming of Hospitals (Lessened Review)
- Ambulatory Surgery
- Ambulatory Care (SNF, HHA and Outpatient Services)

Finally, we have included funds for each PRO to pay providers for the cost of photocopying and mailing of medical records. This is based on a cost of $.05 per page, an average of 100 pages per record, a 50 percent off-site review rate, and $2.40 per case mailing costs.

To establish the number of reviews, we used national estimates of hospital admissions determined by HCFA actuaries, applied actual PRO experience for each type of review and then applied the sampling percentages specified in the third scope of work. The cost of each type of review was determined by using the assumptions shown in Attachment II.

ASSUMPTIONS USED TO DEVELOP BUDGET ESTIMATE FOR FOURTH ROUND CONTRACTS

The budget for the fourth contract cycle is based on the same assumptions used to develop the budget for the third contract cycle, inflated by the estimated increase in admissions and the state and local deflator. No funds were included in the fourth contract cycle for review of physicians office services. We are conducting pilot studies to determine the appropriate methodology to review physician services in an office setting and will not know the review methodology until after the pilots are completed. We will submit a budget request for this activity at that time.

SAVINGS

We estimate that savings resulting from PRO review amounted to $394.6 million for the first round of contracts, approximately $816.7 million for the second round of contracts, and approximately $1,167 million for the third round of contracts (see Attachments III, IV and V).

We calculated these savings by determining (from actual experience) the probable percentage of denials for each type of review and applying that denial rate to the estimated number of reviews that will be performed under the particular scope of work. We then multiplied the number of denials by the average payment per inpatient admission or average outpatient reimbursement to determine gross savings.

These savings are then offset by the percentage of cases that, based on past experience, we expect to be reversed on reconsideration. We then added to the savings from denials to the estimated savings from DRG validation and review of day and cost outliers.

We did not include any savings resulting from the "sentinel effect" of the PRO program.

OVERSIGHT OF THE PRO PROGRAM

HCFA currently maintains continuous program and administrative oversight of PRO contracts through a number of different mechanisms, including:

- use of competitive fixed price contracts;
- periodic onsite review of contractor performance by the project officer;
- performance-based payment of contract vouchers at least monthly;
- external review of the quality of medical review decisions made by the PROs performed by an independent contractor (SuperPRO); and
- use of the PRO Monitoring Protocol and Tracking System (PROMPTS-2) to monitor PRO performance throughout the length of the contract.

During the third scope of work, HCFA is taking the following new steps to improve its control over the PRO program:

- Implementing a new PRO cost reporting form to collect costs by cost accounting category and type of review. This information will be used to analyze whether the negotiated fixed price contract amounts are adequate or excessive in terms of performing the specific activities required by the contract. In addition, such analyses will guide HCFA in negotiating the next round of contracts, especially in determining costs by review type and by PRO.
- Developing up to 5 cost reimbursement contract demonstrations in order to explore this alternative method of funding PROs. These

demonstrations will also help HCFA analyze the cost of reviews and administrative costs in contracts. The cost contracts will include the following characteristics: reimbursement based on the actual cost of work performed according to required standards; monthly vouchers of expenditures with final settlement based on audit at the end of the contract; submission of reports and other deliverables in a timely manner.

- Conducting 10 time/motion (i.e., "engineering") studies to determine the time and cost of performing specific types of reviews and the time and cost for each type of reviewer, such as physicians and nurses. The results of this project will enable HCFA to analyze the time and cost of PRO reviews, which in turn will help us negotiate more reasonably priced contracts and modifications in the future. This data will also help us monitor PRO performance better.
- Developing new audit criteria in cooperation with the Office the Inspector General. This will result in better audits of PRO cost reports.

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ATTACHMENT I

SAMPLINGS AND LEVELS OF REVIEW FOR PRO SCOPES OF WORK

REVIEW SAMPLE	THIRD SCOPE REVIEW LEVEL	SECOND SCOPE REVIEW LEVEL	FIRST SCOPE REVIEW LEVEL
Random Sample	Same	3%	5%
Preadmission	100% of 10 procedures	100% of 5 procedures	Proposed by each PRO
Transfer (PPS to PPS)	50%	Same	100%
Transfer (PPS to Psych)	Same	Same	10% Random All ICD-9-CM, 290-319 All non-psych codes
Transfer (Alcohol)	0%	50%	100%
Transfer (Rehabil.)	0%	50%	100%
Transfer (Swing Bed)	25%	50%	100%
Readmissions	25% random sample on all readmits. w/i 31 days	100% w/i 15 days	100% of related readmits. w/i 7 days of discharge
Medicare Code Editor	Same	Same	100%
Hospital Adjustments	Same	Same	100%

ATTACHMENT I
(Continued)

SAMPLINGS AND LEVELS OF REVIEW FOR PRO SCOPES OF WORK

REVIEW SAMPLE	THIRD SCOPE REVIEW LEVEL	SECOND SCOPE REVIEW LEVEL	FIRST SCOPE REVIEW LEVEL
FI Referrals	Same	100%	100%
DRG 468 (Unrelated Operating Room Procedure	50%	100%	100%
DRG 462 (Rehabilitation)	25%	100%	100%
DRG 088 (COPD)	0%	100%	0%
DRGs 385-391 Newborns	100%	0%	0%
DRG 472 Extensive Burns	100%	0%	0%
DRG 474 Tracheostomy	100%	0%	0%
DRG 475 Mechanical Ventilation with Endotracheal Tube	100%	0%	0%
Day Outliers	25%	50%	100% Reduced to 50% During Contract Period
Cost Outliers	25%	50%	
Percutaneous Lithotripsy	0%	100%	0%
Hospital Notices	Same	100%	100%
Patient is liable	Same	100%	100%
Random Sample	0%	10%	10%

ATTACHMENT I
(Continued)

SAMPLINGS AND LEVELS OF REVIEW FOR PRO SCOPES OF WORK

REVIEW SAMPLE	THIRD SCOPE REVIEW LEVEL	SECOND SCOPE REVIEW LEVEL	FIRST SCOPE REVIEW LEVEL
Specialty Hospitals and Specialty Units Not Otherwise Reviewed	Same	15%	Proposed by each PRO
Assistants at Cataract Surgery	Same	100%	0%
Review of Ambulatory Surgery	5%	0%*	0%
Intervening Care	20%	0%*	0%
HMO	See Attachment IA	See Attachment IA	0%
Intensified Review	Same	50% - 100% of "problems" — 5% or 6 case trigger	100% of "problems" 2.5% or 3-case trigger
Admission Pattern Monitoring	0%	0%	Discontinued During Contract
Champus	Similar to PRO SOW for Medicare Beneficiaries	0%	0%

* Except Pennsylvania

ATTACHMENT IA

SUMMARY OF ACTIVITIES FOR LIMITED HCFA REVIEW OF HMOs

I. Record Review Basis for Selecting Cases	Inpatient Review	Ambulatory Review (Preceding or Without Admission)	Post-Hospital Care Review
*13 Conditions (50% random sample of 4 selected conditions)	Quality (including generic quality screens) Appropriateness Timing of care Premature discharge	Quality Access to care Appropriateness	(review at least 2 of the Conditions asterisked in Attachment 14) Quality Appropriateness Access to care
3% Random Sample of Inpatient cases	Quality (including generic quality screens, discharge review) Underutil., Approp.	—	—
*Deaths (Non-trauma) - in all health care settings (5% random sample)	Access To Care Quality (including generic quality screens) Under utilization Premature discharge Appropriateness	Access To Care Quality (under-utilization) Appropriateness	Access To care Quality (under-utilization) Appropriateness
*Focused Review of Ambulatory Care	—	Quality Access To Care Appropriateness	—
Transfers (100% review)	Quality (including generic quality screens) Approp. of transfer, include. med. stability of pat.	—	—
*Readmissions -25% random sample within less than 31 days	Quality (including generic quality screens) Under utilization Premature discharge	—	Care between admissions (regardless of setting) Quality Access to Care Appropriateness of setting
	Purpose	What to look for	
II. Community Outreach	-To identify quality problems	- Complaints about HMO/CMP care. - Consumer on Governing Board.	

* Sampling maximums apply (see Section B.4 of the scope of work).

ATTACHMENT IA
(Cont'd)

SUMMARY OF ACTIVITIES FOR BASIC HCFA REVIEW OF HMOs

I. Record Review Basis for Selecting Cases	Inpatient Review	Ambulatory Review (Preceding or Without Admission)	Post-Hospital Care Review
**13 Conditions (Select 50% random sample)	Quality (including generic quality screens) Timing of Care Premature discharge Appropriateness	Quality Access to care Appropriateness	(review for 7 of the Cond. asterisked in Attachment 14) Quality Appropriateness Access to care
*** 3% Random Sample of In-patient cases	Quality (including generic quality screens, discharge review) Underutil., Approp.	—	—
**Deaths (Non-Trauma) -in all health care settings (10% Random Sample)	Access To Care Quality (including generic quality screens) Premature discharge Underutilization Appropriateness	Access To Care Quality (under-utilization) Appropriateness	Access To care Quality (under-utilization) Appropriateness
**Focused Review of Ambulatory Care	—	Quality Access To Care Appropriateness	—
Transfers (100% review)	Quality (including generic quality screens) Approp. of transfer, include. med. stability of pat.)	—	—
**Readmissions -50% random sample within less than 31 days	Quality (including generic quality screens) Underutilization Premature discharge	—	Care between admissions (regardless of setting) Quality Access to Care Appropriateness of setting
	Purpose	What to look for	
II. Community Outreach	-To identify quality problems	- Complaints about HMO/CMP care. - Consumer on Governing Board.	

** Sampling minimums and maximums apply (see Section B.4 of the scope of work).
*** Sampling minimums apply (see Section B.4 of the scope of work).

ATTACHMENT IA
(Cont'd)

SUMMARY OF ACTIVITIES FOR INTENSIFIED HCFA REVIEW OF HMOs

I. Record Review Basis for Selecting Cases	Inpatient Review	Ambulatory Review (Preceding or Without Admission)	Post-Hospital Care Review
13 Conditions (100% review)	Quality (including generic quality screens) Timing of Care Premature discharge Appropriateness	Quality Access to care Appropriateness	(review for 7 of the Cond. asterisked in Attachment 14) Quality Appropriateness Access to care
*6% Random Sample of Inpatient cases	Quality (including generic quality screens, discharge review) Underutil., Approp.	—	—
Deaths (Non-Trauma) -in all health care settings (100% review)	Access To Care Quality (including generic quality screens) Underutilization Premature discharge Appropriateness	Access To Care Quality (underutilization) Appropriateness	Access To care Quality (underutilization) Appropriateness
*Focused Review of Ambulatory Care	—	Quality Access To Care Appropriateness	—
Transfers (100% review)	Quality (including generic quality screens) Approp. of transfer, include. med. stability of pat.)	—	—
Readmissions -100% review within less than 31 days	Quality (including generic quality screens) Underutilization Premature discharge	—	Care between admissions (regardless of setting) Quality Access to Care Appropriateness of setting

	Purpose	What to look for	
II. Community Outreach	-To identify quality problems	- Complaints about HMO/CMP care. - Consumer on Governing Board.	

* Sampling minimums apply (see Section B.4 of the scope of work).

ASSUMPTIONS USED TO DEVELOP BUDGET ESTIMATES FOR THIRD SCOPE OF WORK

- Salary Costs

  Salary data collected from the following sources was used to ascertain the costs of the professional staff more heavily involved in the review process:

  - Nurses - Department of Labor statistics for October 1985
  - Physicians - 42 CFR 405.504 A.3
  - Accredited Records Technicians (ARTs) and Registered Records Administrators (RRAs) - American Medical Records Association membership survey for 1983

  Additionally, the State and Local Deflator supplied by OMB was used to inflate wage data to the appropriate fiscal year.

- Review Labor Costs

  Salary cost data and time elements were computed to arrive at the direct labor review cost for each type of review for each PRO area

- Indirect Costs

  Data provided on the HCFA 515 report for 21 randomly selected PROs for the first 12 months of operation was analyzed. Based upon the standardized reporting of expenditures, the data was grouped into major costs centers and a determination was made as to the reasonable relationship of each cost center to the total reported expenditures. The analysis showed that 31 percent of the total expenditures were associated with direct labor review costs and 69 percent of the total expenditures related to indirect costs. Thus, by the application of the indirect cost rate and the direct labor cost rate, the Government estimate was derived for each type of review for each PRO area.

- Validation of Estimates

  To aid in refining PRO by PRO estimates, the following two projects were undertaken:

  - Time and Motion Studies

  In fiscal year 1988, HCFA solicited contracts with major accounting firms in six PRO areas to perform time and cost studies associated with each type of review. Contracts were negotiated in two such areas and the results were used to evaluate the time and cost estimates used in developing the costs associated with the third scope of work.

- Review of Cost Allocation Reports

  As part of the contract deliverables, PROs are required to submit a semi-annual report of their expenditures by cost center and review category. These data were used to develop the cost of each review for the Government estimate.

Attachment III

PEER REVIEW ORGANIZATIONS
SAVINGS
(Dollars in Thousands)

FIRST CONTRACT CYCLE:

PRO Denials	206,829
Less: Denials Paid Under Waiver	(86,827)
Total PRO Denials	120,002
Less: Denials Reversed or Modified	(41,400)
Net Denials	78,602
Multiply by: Average Reimbursement Amount	$ 3,351
Net Savings from PRO Denials	$ 263,395,302
Add: DRG Validation Savings	$ 27,445,984
Cost Outlier Savings	$ 51,919,362
Day Outlier Savings	$ 51,805,558
TOTAL NET SAVINGS	$ 394,566,206

Attachment IV

PEER REVIEW ORGANIZATIONS
SAVINGS
(Dollars in Thousands)

SECOND CONTRACT CYCLE:

Total PRO denials	193,460
Less: Denials Reversed or Modified	(24,984)
Net Denials	168,512
Multiply By: Average Reimbursement per Denial	$ 4,465
Net Saving from PRO Denials	$ 752,406,080
Add: DRG Validation Savings	$ 27,176,382
Cost Outlier Savings	$ 18,730,068
Day Outlier Savings	$ 18,359,175
Total Savings	$ 816,671,705

Attachment V

PEER REVIEW ORGANIZATIONS
SAVINGS
(Dollars in Thousands)

THIRD CONTRACT CYCLE:

Total PRO denials		316,806
Less:	Denials Reversed or Modified	(40,852)
Net Denials		275,954
Multiply By:	Average Reimbursement per Denial	$ 3,844
Net Saving from PRO Denials		$ 1,060,767,176
Add:	DRG Validation Savings	$ 44,909,864
	Cost Outlier Savings	$ 30,951,437
	Day Outlier Savings	$ 30,338,537
Total Savings		$ 1,166,967,014

RESEARCH

FY 1990

RESEARCH

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Decision Unit - Research, Demonstration and Evaluation Projects
(Budget Account - 75-0511-0-1-550)

Analysis of Resources
(Dollars in Thousands)

Total Program Level	FY 1988	FY 1989	FY 1990
Total Obligations	$26,807	$32,000	$61,000
Less Trust Fund Transfer	(17,233)	(20,571)	(47,000)
Budget Authority	9,574	11,429	14,000

Total Program Level	FY 1991	FY 1992	FY 1993	FY 1994
Total Obligations	$103,188	$145,229	$149,295	$152,729

RESEARCH, DEMONSTRATION AND EVALUATION BUDGET

Authorizing Legislation - Social Security Act, Sections 1110, 1115, 1121(b)(2), 1875 and 1881(a); Rural Health Clinic Act, Section 3.

	FY 1989 Current Estimate	FY 1990 Estimate	Increase or Decrease (+/-)
Total Obligations	$32,000,000	$61,000,000	$+29,000,000
Less Trust Fund Transfer	(20,571,000)	(47,000,000)	
Total Budget Authority	11,429,000	14,000,000	

Research Goals

The proposed budget reflects HCFA's and the Administration's primary research, demonstration and evaluation goals which are listed below:

1. Continued access to quality of care under Medicare and Medicaid and improved methods for measuring quality and effectiveness of care;
2. Refinement and reform of the current Medicare physician payment system through the study of the causes for the growth in Medicare outlays for physician services and the testing of alternative payment/delivery systems (e.g., physician preferred provider organizations);
3. Increased competition and consumer choice and continued growth of the private health plan option;
4. Continued improvement of the current Medicare hospital prospective payment system (PPS) and study of the outpatient delivery and financing system;
5. Analysis of other Medicare and Medicaid program issues including clinical laboratory, durable medical equipment, and ambulatory surgical center services; and
6. Further research in the areas of long-term care, subacute care, and beneficiary awareness and prevention.

The budget also reflects the continuation of a large number of congressionally-mandated research, demonstration, and evaluation projects. Estimates at this time (which have taken into consideration the mandates in the 1987 Omnibus Budget Reconciliation Act but have assumed no new congressional mandates resulting from catastrophic health care legislation or other 1988-1990 legislation) are that during fiscal year 1990, HCFA will spend $17 million for these projects.

Purpose and Method of Operations

The Health Care Financing Administration's (HCFA) research, demonstration and evaluation (RD&E) activities provide knowledge to enable the Administrator, the Secretary, the Office of Management and Budget, the Congress and other interested parties to make informed and rational decisions regarding HCFA program, policy, and budget decisions.

Historically, the costs of health care services have been increasing more rapidly than those of the general economy. This has meant that not only the absolute number of dollars spent on health care has increased rapidly, but also that the proportion of the Gross National Product related to total health care expenditures has steadily increased. Between 1967 and 1986, national health expenditures increased from 6.4 to 10.9 percent of the Gross National Product.

In fact, Medicare and Federal Medicaid expenditures, as a percent of total national health care expenditures, have increased from 15 percent in 1967 to a projected 30.2 percent in 1990. Over the next 10 years, Medicare expenditures under Parts A and B are expected to experience a 150 percent increase over current levels; given current rates of inflation, Medicare spending will surpass Social Security benefit payments within the next 25 years. Thus, HCFA, as the leading purchaser of health care in the United States, is charged with finding ways to control the spiraling trend of such costs while insuring that every dollar is used effectively in the service of HCFA beneficiaries.

HCFA's RD&E activities are focused in areas that directly relate to the Medicare and Medicaid programs. Because Federal expenditures under these programs are estimated at more than $145.9 billion in 1990, and given the rates of increase discussed above, there is a significant Federal interest in the development and testing of alternatives to administer these programs in more efficient and cost-effective ways. HCFA's RD&E program has consistently produced results that have saved substantially more in program dollars than the cost of the RD&E. The work done with Yale University and the State of New Jersey on a hospital PPS based on diagnosis-related groups is the most frequently cited example of the results of HCFA-funded efforts (the largest domestic reform of the last decade, this system affects over $40 billion annually in outlay distribution).

In addition to PPS, HCFA has funded a number of other major efforts that have impacted substantially on program outlays and the structure of the health care financing system. Examples include:

- Demonstrations of the health maintenance organization concept;

- Research done on Medicare skilled nursing facility payment limits and research used as the basis for the Institute of Medicine recommendations on conditions of participation for nursing homes;
- Assistance provided to States in the development of case-mix payment methods for nursing homes;
- Research on overpriced payments for physician services (which led to changes in the Omnibus Budget Reconciliation Act of 1987 expected to result in savings to the Medicare program of $100 million annually);
- Research on payment levels for clinical laboratory services (projected annual program savings of $50 million); and
- Research on outlier payment policy.

Furthermore, we have recently initiated major new efforts which are expected to provide important findings for shaping future policy decisions and achieving additional savings:

- Development of the geographic cost of practice index and examination of additional potentially overpriced procedures (consultations, cataract surgery, "global" visit payments, etc.);
- Research on capital payments (including excess capacity and construction costs);
- Development of outpatient surgery payment rates;
- Demonstration of providing respite care and other support services to families of Alzheimers disease patients; and
- Refinement of the current payment methodology for services provided in health maintenance organizations (including studying the feasibility/advisability of geographic reconfigurations to the AAPCC method and studying the diagnostic cost group model as an alternative model).

Congress has also repeatedly recognized the importance of this role by requiring that potential program changes be investigated by means of demonstrations before the enactment of full-scale legislative program changes and by mandating reports relative to the evaluation of the program implementation.

Rationale for the Budget Request

The fiscal year 1990 request for funding of HCFA's research, demonstration, and evaluation activities is $61 million ($36 million, plus $25 million for Effectiveness Initiative). The budget proposed for FY 1990 constitutes approximately three-hundredths of one percent of estimated FY 1990 Federal Medicare and Medicaid expenditures. The budget represents continuation of research, demonstration, and evaluation activities ($27.3 million), start-up of new projects that support congressional mandates and HCFA's and the Department's priority initiatives ($8.7 million), and a major expansion of the Effectiveness Initiative ($25.0 million).

The Effectiveness Initiative was begun in response to a growing concern on the part of HCFA and the Department, the Congress, and the beneficiary population over the need to structure a system that facilitates the development of knowledge about the effectiveness of services provided to Medicare beneficiaries. A multi-year agenda with six specific activities has been designed to build upon current efforts underway within HCFA. The goal of this coordinated agenda is to improve our current monitoring systems for examining outcomes and effectiveness of care received by beneficiaries, and to use the results of this enhanced monitoring system to identify needed studies of effectiveness to improve the overall quality of care provided under the Medicare program.

The planned agenda builds on the efforts begun in 1987-88 (the Medicare hospital mortality data release, the expanded research effort designed to develop other valid quality of care outcome measures, the convening of experts in the quality and effectiveness of care field to help shape the future agenda in this area) through the implementation of a 4-year (1989-1992) phase-in of the full-scale initiative.

Briefly, the initiative has a three-pronged strategy. First, we will be upgrading our current data systems to enhance our ability to monitor quality and effectiveness of care. This upgrade will follow two concurrent paths: (a) increase the current hardware/software capacity available to us to permit more efficient use of available data/linked data sets and (b) implement an expanded information-gathering initiative to collect patient-specific health status data to complement current administrative data and permit more focused research efforts.

Second, we will be expanding the current research and demonstration efforts underway within HCFA on quality and effectiveness of care provided to program beneficiaries. This expanded R&D effort will build on (a) the present peer review organization (PRO)-conducted, provider-oriented effectiveness monitoring research; as well as (b) the current research and demonstration efforts conducted/funded by the Office of Research and Demonstrations to develop valid quality of care outcome measures, measure the impact of program changes on quality of care, and determine the effectiveness (in terms of outcome and costs) of services provided to program beneficiaries.

Finally, we will be expanding our dissemination and training efforts in the effectiveness area. This enhanced outreach initiative is designed to (a) improve the utility of quality of care outcome information provided to program beneficiaries (as consumers) and the feedback given to providers and practitioners about the quality and effectiveness of care they are providing, and (b) develop an ongoing HCFA training (fellowship) program for health care practitioners (and students) to develop national expertise in effectiveness evaluation.

Total projected costs during the 3-year period of FY 1990-92 are $50 million in FY 1990 (including $25 million for research and demonstrations); $100 million in FY 1991 ($66 million for research and demonstrations); and $150 million in 1992 ($107.5 million for research and demonstrations). Thereafter, annual expenditures will remain at approximately the $150 million level (adjusted for inflation). Fiscal year 1989 expenditures ($8.4 million) were reflected in the 1989 budget request. This phase-in approach allowed us in FY 1989 to build on and modestly expand the efforts begun in 1987 ($4.2 million) and 1988 ($4.9 million), laying the foundation (both conceptually and in terms of developing the necessary funding announcements) for the expanded efforts in FYs 1990-92.

In addition to expanding our efforts in the effectiveness area, and to fulfilling our obligations to conduct congressionally-mandated studies and reports (in FY 1990, projects supporting congressional mandates total $17 million), we plan to continue our balanced research program focusing on short-term (0-2 years), mid-term (2-3 years), and long-term (3-5 years) research. We also plan on continuing a number of major efforts that support effective ongoing management of the programs, particularly in the areas of analyses for the annual PPS update regulation and ongoing PPS refinement issues.

Below are the major priority areas that cross-cut our short-, mid-, and long-term objectives:

Further Study to Develop and Refine Measures of Quality and Effectiveness of Care. We will be expanding our efforts directed toward measuring the quality and effectiveness of care provided to beneficiaries and ensuring that quality health care remains accessible to beneficiaries, particularly as the nature of the payment system changes. We will place major emphasis on studies designed to develop ways to measure patient outcomes in a variety of treatment settings and under different payment systems, and on studies designed to assess the effectiveness of specific procedures/services.

Refinement and Reform of the Current Physician Payment Methodology. We will be placing increased emphasis on efforts aimed at refining and reforming the current physician payment system, particularly under Medicare. We will be expanding current efforts to study the causes for the growth in Medicare outlays for physician services and to develop data bases and models that will allow us to better understand policy alternatives and test their impact. We will also be continuing our study of the physician preferred provider organization concept as a cost-effective alternative payment/delivery system.

Expansion and Further Study of the Medicare Private Health Plan Option. We will continue to direct significant effort to designing and testing alternative payment methods for services that will

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increase competition in the health care marketplace, while ensuring the continued quality of care. Most notably, as part of our goal to increase the opportunities for beneficiary choice, we will be investigating the growth of health maintenance organizations and competitive medical plans under the current capitation system, and designing demonstration projects to test different capitation systems. We will also be continuing work already begun to examine the advisability of adjustments (e.g., geographic reconfiguration) to the current AAPCC methodology or alternatives (e.g., the diagnostic cost group model) to this methodology.

Continued Refinement of the Medicare Hospital Payment Methodology. We will be continuing our efforts to refine the current Medicare hospital PPS. We will also be continuing our assessment of the impact of the Medicare hospital PPS on varied segments of the health care delivery and financing system, especially on beneficiary access to quality care.

Analysis of Medicare Clinical Laboratory, Durable Medical Equipment, and Ambulatory Surgical Center Payment Policies. We will be expanding our efforts toward determining the appropriate Medicare payment policies for clinical laboratories, durable medical equipment, ambulatory surgical centers, and other areas. We will be conducting resource-based analyses of these services and examining private sector payment policies in developing our policy alternatives.

The following chart reflects the seven program (priority) areas, with associated funding in FYs 1988, 1989, and 1990 in which HCFA's research, demonstration, and evaluation projects are conducted.

FUNDING BY PROGRAM AREA

Program Areas	FY 1988 Budget	FY 1989 Current Estimate	FY 1990 Estimate
1. Quality and Effectiveness of Care	4,901,563	7,918,382	34,942,996
a. New	3,148,134	2,250,000	27,300,000
b. Continuations	1,753,429	5,668,382	7,642,996
2. Physician Payment	$4,952,209	$6,112,036	$5,300,000
a. New	2,075,000	250,000	2,500,000
b. Continuations	2,877,209	5,862,036	2,800,000
3. Alternative Payment Systems	6,438,254	6,970,225	7,741,501
a. New	2,566,531	2,375,000	1,500,000
b. Continuations	3,871,723	4,595,225	6,241,501
4. Hospital Payment	4,019,649	2,995,000	3,097,500
a. New	2,600,000	--	500,000
b. Continuations	1,419,649	2,995,000	2,597,500
5. Program Efficiencies, Analyses, & Refinements	3,409,295	3,802,000	3,071,878
a. New	1,340,000	250,000	1,019,878
b. Continuations	2,069,295	3,552,000	2,052,000
6. Beneficiary Awareness & Prevention	2,143,741	2,113,000	4,146,125
a. New	1,524,000	--	200,000
b. Continuations	619,741	2,113,000	3,946,125
7. Subacute and Long Term Care	942,289	2,089,357	2,700,000
a. New	250,000	1,500,000	700,000
b. Continuations	692,289	589,357	2,000,000
TOTALS:			
New	13,503,665	6,625,000	33,719,878
Continuations	13,303,335	25,375,000	27,280,122
Total Program	$26,807,000	$32,000,000	$61,000,000

QUALITY AND EFFECTIVENESS OF CARE

	FY 1989 Current	FY 1990 Budget Request
New Awards	$ 2,250,000	$ 27,300,000
Continuations	5,668,382	7,642,996
Total	$ 7,918,382	$ 34,942,000

GOAL: To ensure the continuation of quality health care provided to program beneficiaries and access to required levels of care. To improve our ability to accurately measure the quality and effectiveness of such care.

RATIONALE: The implementation of the hospital prospective payment system was intended to provide an economic incentive to restrain resource use and to maximize efficiency in the provision of inpatient care. Although the average length of stay was expected to fall under this new payment system, the actual decrease experienced is more pronounced than had been projected. Contrary to nearly universal expectations, admission rates under PPS have fallen. Section 603(a)(2)(A) of the Social Security Amendments of 1983 (P.L. 98-21) mandated that we study and report on the impact of the hospital prospective payment system on Medicare beneficiaries. A major aspect is the impact of the prospective payment system on the quality and effectiveness of care provided to beneficiaries. The decreased inpatient hospital resource utilization resulting from this system has raised concerns as to whether the quality and effectiveness of care provided has been adversely affected; or whether access to needed levels of care has been limited. The rapid changes in other Medicare and Medicaid program areas make it even more critical that we ensure the care provided under Medicare and Medicaid is of high quality and effective in treating health care needs.

STRATEGY: In order to assess the impact of program payment changes on the quality and effectiveness of care provided to program beneficiaries, it is essential that we expand our efforts to develop and refine valid quality of care measures for different treatment settings and our efforts to assess the effectiveness of care provided to program beneficiaries. In FY 1990, we will be substantially expanding our efforts in the following areas: study of the effectiveness of specific procedures for given diseases/symptoms, development and use of reliable and valid outcome measures to assess processes of care, enhancement of current data sets for use in assessing quality of care and outcomes, and development of quality of care measures and monitoring systems for other than inpatient care.

1. Effectiveness Studies. We plan to expand substantially efforts that address the effectiveness of specific medical or surgical interventions. We will be conducting

empirically-based research and demonstration studies to determine the effectiveness (both in terms of outcomes and costs) of covered and noncovered services under the Medicare Program, where the effectiveness is in question, where there are wide geographic differences in rates of services, where there is great variability in physician practice patterns, and where there are differences in the practice setting; or when the impact of a new technology in the Medicare population needs to be evaluated. We will be evaluating the outcomes and effectiveness of existing services (e.g., carotid endarterectomy; hip fracture procedures; joint replacement; and cholecystectomy), as well as the outcomes of alternative treatments used for the same condition (e.g., CABG vs. coronary angioplasty vs. medical treatment for unstable angina; and surgery vs. medical treatment for spinal conditions).

We will be evaluating the outcomes and effectiveness of care provided in different settings (e.g., inpatient vs. outpatient surgery for hernia repair), as well as the impact of new technologies (e.g., TPA; erythropoiten; hemodiafiltration).

To enhance our ability to monitor outcomes of medical interventions, we will develop an ongoing epidemiological surveillance system (Medicare Beneficiary Health Status Registry) that collects information about successive cohorts of new beneficiaries through a survey of 5 percent sample of newly entitled Medicare beneficiaries each year (about 90,000 persons). This system will allow us to monitor the health status of the Medicare population by gathering information on the incidence and prevalence of disease, disability, and other factors which influence health.

We will also be gathering health and functional status information from Medicare beneficiaries after hospitalization to serve as additional measures of the effectiveness of hospital care (beyond the currently available mortality and rehospitalization data). Patient information will be collected after discharge from the hospital, with a major item of interest being the functional status of the patient in areas related to the reason for admission. Patients hospitalized for high volume and/or high cost admissions or procedures would be targetted. Similarly, patients hospitalized for treatments and procedures for which morbidity or functional status are better measures of outcome than is death would be targetted.

2. Alternative Outcome Measures and Their Use. Little advancement has been made in the development of additional measures of patient outcomes that can be used in quality of care studies. Most studies currently use mortality or rehospitalization rates. Research is needed to develop reliable and valid measures of patient outcome that are

sensitive to variations in the quality of care. We plan to examine the relationships between the processes of medical care and the resultant outcomes of care.

3. Data Enhancement. The Health Care Financing Administration has used a variety of administrative data available for quality of care research and demonstrations. However, administrative data are limited with regard to beneficiary health and socio-demographic characteristics. Other data sets, supported by private and public initiatives, may have the potential, at low cost, to enhance HCFA's data bases, especially if they can be linked to administrative data. We plan on initiating studies which will carry out epidemiologic and other quality of care and effectiveness research using linked administrative data sets.

4. Quality of Care Related to Hospitals

   - Access to Hospital Care. The reduction in Medicare and Medicaid overall admissions has put pressure on providers to cut back on available beds, consolidate resources and in some cases may even result in hospital closings. In terms of the entire health care system these changes probably reflect improvements in efficiency. However, it is possible that certain groups of beneficiaries may have difficulty in getting needed inpatient care. We plan to continue studies examining the extent to which beneficiary access to hospital care may have changed as a result of the prospective payment system.

   - Quality of Care While in the Hospital. Quality of inpatient care could be greatly affected by prospective payment system incentives, particularly in light of shortened lengths-of-stay, personnel reductions, and incentives to reduce ancillary services. We plan on addressing a number of specific problems through studies in the following areas:

     - There is considerable variation across hospitals in such quality of care outcome measures as mortality and rehospitalization. Other than basic covariates such as diagnosis, age and sex, there is little information on variations in severity of illness that may account for these differences.

     - There are many changes taking place in the provision of medical care that are outside of the hospital setting which could impact on the assessment of quality of care in the hospital. One is the movement of many surgical procedures to the outpatient setting. A second is a trend toward the placement of terminal patients out of the hospital into long term care facilities and to home settings (i.e., hospices). Studies are needed that examine the impacts these and other health care delivery trends have on the provision of inpatient care and the assessment of that care.

- We plan on initiating projects to develop nationally representative expected outcomes for selected groups of diagnoses and/or procedures. We are interested not only in the outcomes, but also in severity adjustments and process indicators which can be of direct use to health care providers in the assessment of their own performance. Priority will be given to projects that center on diagnoses and/or procedures which account either for significant proportions of hospital case load or significant proportions of negative outcomes (e.g., deaths, readmissions, complications, etc.).

o Access to Needed Post-Hospital Subacute Care. Perhaps the greatest concern occurring as a result of reduced lengths-of-stay is that patients are being discharged to the home from hospitals before they have recovered sufficiently. This concern revolves largely around the issue of access to post-discharge services. We plan on continuing a major national study that examines the levels of need for post-hospital care, the extent to which these needs are being met, and the sources providing post-discharge services (home health agencies, skilled nursing and intermediate care facilities, physicians, outpatient departments, and informal care networks).

5. Quality Issues in Long Term Care, Physician Care, and Outpatient Care, and the Medicaid Program

o Long-Term Care/Physician Services Outcome Measures/Monitoring Systems. We plan to continue projects designed to develop, demonstrate, and evaluate quality of care outcome measures and monitoring systems for nursing homes, home health agencies, and physician services.

o Outpatient Care. We also plan to fund projects that develop an overall approach to quality standards, monitoring, and improvement in the area of outpatient care (including both surgical and non-surgical services). Such an approach should be designed to move towards minimum quality standards applicable across the various outpatient care settings and across various payment mechanisms. We plan on studying issues related to the quality of outpatient care, including the appropriateness of services rendered for specific conditions.

o Medicaid Quality of Care. We will be continuing our study of the appropriateness, necessity and effectiveness of treatments and procedures received by Medicaid beneficiaries as mandated by section 9432 of the Omnibus Budget Reconciliation Act of 1986.

6. **ESRD Quality of Care Studies.** We will be examining access to treatment and quality of care provided to the end stage renal disease population as required under section 4036(d) of OBRA 1987.

PHYSICIAN PAYMENT

	FY 1989 Current	FY 1990 Budget Request
New Awards	$ 250,000	$ 2,500,000
Continuations	5,862,036	2,800,000
Total	$ 6,112,036	$ 5,300,000

GOAL: To identify, develop, demonstrate and evaluate effective refinements and alternatives to control the costs of physician reimbursement under Medicare and Medicaid while maintaining a high quality of care. To enhance physician data base systems to determine the financial impact of different physician payment policies.

RATIONALE: Over the past 10 years, Medicare payments for physician services grew at a rate of nearly 20 percent a year; in 1990, expenditures are expected to be $30.4 billion. We believe it is important to understand the cost, volume and intensity factors of outlay growth in order to develop reforms to control the high growth rate of the current payment system. We also believe it is important to analyze the impact of recent physician reforms on access to care and quality.

STRATEGY: It is critical to develop a detailed data base on physician payments in order to, first, understand the underlying factors which have resulted in the rapid growth in physician costs and, second, develop refinements to the current system in order to control these costs. We will be building on and extending a major data collection effort initiated in FY 1987 to provide the capability to analyze the factors leading to the growth in physician expenditures.

1. **Physician Preferred Provider Organizations.** We plan to continue a series of projects initiated in FY 1988 that study and test the cost-effectiveness and feasibility of the preferred provider concept in a fee-for-service setting for physician services provided to Medicare beneficiaries. The prime objectives of the projects are to maintain quality and access to care, as well as to generate Medicare savings.

2. **Physician Utilization and Intensity Issues**

   o Analysis of Physician Costs Related to Changes in Volume and Intensity of Services. We will continue studying the procedures and specialties for which volume and intensity changes have been the largest. We will be attempting to break out the causes and forces driving the increases in expenditures for physician services into more manageable parts. In addition, we plan on studying how changes in intensity of physician services, including the introduction of new procedures, changing the number of services per procedure, and increasing the intensity of medical examinations, have affected Medicare expenditures. We also plan on studying physician practice variations in different geographic areas and their implications for Medicare expenditures. Finally, we plan on studying, on a static and dynamic basis, the volume and intensity of physician services per beneficiary.

- Develop Methods to Improve Physician Utilization Review Screens. We plan on developing ways to improve the current medical utilization review mechanism for physician services through analyzing private sector initiatives in this area and through soliciting research projects.

- Effect of Payment Method on Physician Services. We also plan to continue studying the effect(s) of different payment methods (e.g., HMO, PPO, fee-for-service) on the volume and composition of physician services for different medical conditions.

3. Physician Pricing Issues

- Analysis of Overpriced Procedures. We plan to continue developing methodologies to determine if Medicare's payment for certain procedures is excessive. Such projects might include procedures that are overpriced due to decreasing costs, difficulty and/or risk for the procedure. The analysis will include a comparison of the procedure for which Medicare payment is too high compared to related procedures, to procedures in other geographic areas, or to payment by other payors. Examples of payment areas receiving particular attention include billings for diagnostic test interpretations and visits, billings for the technical components of diagnostic tests, payments for anesthesia services and consultations. The physician cost of practice index will continue to be refined in order to standardize physician payments to reduce overpriced procedures. We also plan on studying whether global fees for surgical cases are too high (for example, because of decreases in lengths-of-stay).

- Evaluation of the Impact of Physician Payment Reforms on Access and Quality. Since 1984, Congress has enacted legislation reforming the payment structure for physician services; e.g., the physician fee freeze, the participation program, overpriced ophthalmology procedures, assistants at surgery, and reductions in anesthesia payments. We plan on analyzing the effect that Congressional action has had on beneficiary access to and the quality of physician services. We also plan on examining how price, payment, service volume and beneficiary liability distributions differ among beneficiaries having similar illnesses, and whether any types of beneficiaries have been significantly disadvantaged by any of the recent legislative charges.

- Redistributive Impact of Refinements to Current Physician Payment Methods. We plan to continue studying the redistributive impact of refinements to current physician payment methods on beneficiaries and their out-of-pocket costs; physicians and their practice revenues; and participation and assignment rates by geographic areas (carriers, States, localities, within localities), specialty, site of service, type of services, etc. We will study projects that analyze charge distributions within areas and among areas, for example, the percent of customary charges at and above the prevailing charge.

- Appropriateness of Pricing Level for New Physician Procedures. We plan on studying the volume of new procedures which have been recognized by Medicare over the past 10 years and determining the appropriateness of the payment level by comparing the procedure payment to payments from Medicare contractors and private sector payors.

4. **Analyses of Public and Private Sector Physician Markets**

- Analysis of Physician Responses to the Changing Medical Environment. With the increase in the number of physicians per capita and the more competitive structure of the health care system, changes in physician practice style have occurred. We plan on obtaining information on how physicians have responded to the more competitive health care environment. The study would result in gathering data on the following items and examining how these data have changed over time:

    - Physician employment arrangements, including solo practices, hospital-based physicians, group practices, HMOs/CMPs, IPAs, and PPOs.
    - Medicare's share of the physician's practice by specialty and procedure. We will study the distribution of Medicare payment within each specialty and major procedure.
    - The specialties that graduate medical students are entering and the reasons for changes.
    - Physicians' net receipts per Medicare patient compared to those for patients of other payors, and the impact such differences have on Medicare's share of physicians' practice income.

- Study of Private Sector Physician Initiatives. In recent years, there has been a dramatic growth in private sector efforts to develop and apply improved approaches for monitoring and containing the volume and intensity of physician services to insured patients. A growing number of private firms specialize in operating service review mechanisms for employees, health plans and insurers. These complement the many forms of medical organization service review arrangements pioneered by Medical Foundations, PSROs and PROs.

We plan on gathering information on private sector initiatives for controlling physician expenditures. Specifically, the following is planned:

- Descriptions of how private sector plans control the rapidly growing volume and cost of physician services.
- Determinants of how private sector initiatives can be applied to Medicare.
- A better understanding of the changing relationship between physicians and capitated plans, hospitals, nursing homes, home health agencies, and other providers.
- A comparison of the Medicare payment allowances and private sector payment allowances.

5. Other Areas for Continued Study

- Appropriateness of payments for assistants at surgery.
- Volume of physician consultation services in hospitals over time and the types of physicians who are performing these services.
- Labor inputs for anesthesia services for which we plan on comparing the payment rates for anesthesiologists and certified nurse anesthetists.
- Impact of DEFRA clinical laboratory fee schedule on growth in physician laboratories and the volume of laboratory tests.
- Changes in the utilization of physician diagnostic services such as endoscopies and colonoscopies.
- Variations in assignment rates by geographic area, specialty and site of service.
- Variations in charges for teaching physicians and the extent to which they are involved with patient care.

ALTERNATIVE PAYMENT SYSTEMS

	FY 1989 Current	FY 1990 Budget Request
New Awards	$ 2,375,000	$ 1,500,000
Continuations	4,595,225	6,241,501
Total	$ 6,970,225	$ 7,741,501

GOAL: To identify, develop, demonstrate, and evaluate effective alternative health care delivery and/or payment systems to control

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Medicare and Medicaid payments without sacrificing the quality of care. To promote expanded opportunities for beneficiary choice by moving towards payment systems based on capitation and competition in the marketplace, and to promote the Medicare private health plan option initiative.

RATIONALE: Prior RD&E activities, which focused primarily on health maintenance organizations (HMOs), indicated that alternative delivery systems and alternative risk reimbursement mechanisms are cost-effective and offer Medicare and Medicaid beneficiaries the opportunity for improved benefits over the existing fee-for-service system, primarily by decreasing hospital use and offering ambulatory and preventive care services. There is also a need to test other delivery and financing systems that enhance competition and promote Medicare program efficiencies.

STRATEGY: We believe that the continued growth of opportunities for expanded beneficiary choice can best be accomplished through two mechanisms:

- Promoting growth of HMOs and CMPs under the current capitation structure. By refining the Adjusted Average Per Capita Cost (AAPCC) to more accurately reflect the costs of treating a Medicare enrollee and by lowering the barriers to entry into capitated systems, the incentive for growth in HMOs and CMPs should dramatically increase.

- Designing demonstration projects to test different payment systems. In conjunction with promoting growth of capitated systems under the current law structure, we believe it is necessary to test alternative payment systems through demonstration projects. As part of this effort, we are interested in supporting research and demonstration projects that develop and test payment systems that provide incentives to Medicare and Medicaid beneficiaries to be informed purchasers of health care plans and services, including payment systems based on capitation and competition in the marketplace and consumer information projects that support such systems.

We believe that cost-effective use of Medicare services can be promoted effectively through developing and testing alternative payment systems, with emphasis on the rapidly growing areas of outpatient care and post-hospital subacute care services.

1. **Private Health Plan Option (PHPO) Pricing Issues**

   - Refinements to Adjusted Average Per Capita Cost Formula. Medicare reimbursement to HMOs and CMPs is based on the Adjusted Average Per Capita Cost (AAPCC) formula. The current formula uses age, sex, welfare status, and institutional status as factors to predict the per capita amount that would be payable if Medicare services for HMO members were furnished in the local fee-for-service market.

In late 1987, HCFA arranged for a study of the AAPCC from the actuarial firm of Milliman and Robertson. HCFA then convened a panel of experts from the HMO industry, academia, and government to review the report and develop a set of recommendations for refinement of the AAPCC. The two primary recommendations for future work on AAPCC refinement were (1) to continue to study alternative ways of defining geographic areas used in the AAPCC calculation (which we are doing through our current research centers) and (2) to continue research and demonstrations on the diagnostic group (DCG) model of paying HMOs.

- Alternative, Market-Oriented Pricing Methods for Payments in Capitated Systems. Medicare's payment for services provided in HMOs is based on per capita costs in the fee-for-service sector. One issue we plan to address is what happens to pricing mechanisms when Medicare's at-risk penetration is large and the number of fee-for-service beneficiaries is diminished. Particularly, what distortions occur in the pricing mechanisms and what alternatives for pricing benefit packages exist, such as negotiated pricing in areas that experience high HMO/CMP market penetration?

2. Enrollment and Disenrollment Issues/Continuation of HMO/CMP Monitoring Systems

Per capita health care costs in HMOs/CMPs are generally lower than in the fee-for-service sector. The capitation approach contains incentives for efficiency and resource-use awareness. Recent studies have also suggested that part of the reason for lower rates in HMOs/CMPs may be favorable selection of or by low users of health care. We plan to continue the program evaluation of TEFRA HMOs/CMPs, which examines several issues of interest, including biased selection, quality of care, market entry, disenrollment, and AAPCC accuracy. Similarly, we plan to initiate projects on how HMOs/CMPs achieve their savings, including comparisons of the types and quality of services received in HMO/CMP and fee-for-service populations, as well as studies of health plan behavior (including marketing) that may result in favorable selection. Issues to be studied include the following:

- The impact of types of services offered by HMOs/CMPs on access to services and favorable or unfavorable selection.
- Factors that explain enrollment and disenrollment in HMOs/CMPs and their relation to biased selection.
- The difference in health status among HMO/CMP and fee-for-service enrollees.
- Studies that measure the difference in health status among HMO/CMP enrollees and beneficiaries in the fee-for-service

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sector and that analyze any difference in terms of the health status of new enrollees, disenrollees, and continuing members.

- Studies/economic analyses of the behavior of health plans within the context of the local market for health care. Competitive behavior in terms of pricing, benefits, marketing, expansion, and mergers are areas of interest.

3. **Other Alternative Payment Systems and Issues**

- Physician Preferred Provider Organizations. We plan to continue a series of projects initiated in FY 1988 that study and test the cost-effectiveness and feasibility of the preferred provider concept in a fee-for-service setting for physician services provided to Medicare beneficiaries. The prime objectives of the projects are to maintain quality and access to care, as well as to generate Medicare savings.

- Coronary Artery Bypass Graft (CABG) Demonstration. We plan on continuing our study of the cost-effectiveness and feasibility of an all-inclusive CABG surgery package price arrangement with selected groups under Medicare. As in the case of the physician PPO model, the prime objectives of the projects are to maintain quality and access to care, while generating real Medicare savings.

- Alternative Payment Methodologies for Outpatient Services. We plan to continue studying methods that will assist us in working toward prospective payment for hospital outpatient services. Although we currently have several projects that are working toward the development of prospective payment for ambulatory surgery, we plan to study additional services (such as radiology services, emergency services, general medical services, and other clinic services typically utilized by Medicare patients) that might provide new and innovative concepts in this area. Among the issues that need to be addressed are: refinement and application of existing patient classification systems; the possibility of applying payment limits; bundling of services for payment; identification of justifiable cost differences between hospitals and across all ambulatory care settings for similar care; and innovative payment methodologies.

- Medicaid Capitation Rates. Capitated arrangements are becoming more prevalent as a mechanism for States to purchase and/or finance health care under the Medicaid program. Such arrangements may be with counties, health insuring organizations, or other prepaid organizations. One area of particular interest is coverage of joint Medicare and Medicaid beneficiaries under Medicare-qualified capitated HMOs and CMPs. The equity of the rate-setting methodology is critical, particularly as more capitation arrangements are established. A variety of rate-setting methodologies have been employed, and we plan on studying the factors and the methodologies which result in fair and accurate capitation rates. We also plan on testing refinements in the capitation payment models developed by States.

- Bundled Payment for Skilled Nursing Facility and Home Health Services. We plan to continue our study of the feasibility of a bundled hospital DRG payment which includes payment for both SNF and HHA services.

- Prospective Payment for Home Health Services. We plan to continue the demonstration and evaluation of alternative methods of paying home health agencies on a prospective basis for services furnished under the Medicare and Medicaid programs as mandated by the Omnibus Budget Reconciliation Act of 1987.

- Evaluation of Social HMO Demonstration. We also plan to continue our evaluation of the congressionally-mandated Social HMO demonstration.

HOSPITAL PAYMENT

	FY 1989 Current	FY 1990 Budget Request
New Awards	$ 0	$ 500,000
Continuations	2,995,000	2,597,500
Total	$ 2,995,000	$ 3,097,500

GOAL: To continue to analyze, evaluate, and refine the Medicare prospective payment system for hospitals while maintaining a high quality of patient care. To study cost-efficiencies and refinements for payment of outpatient, capital, medical education, and services provided by excluded hospitals/hospital units.

RATIONALE: Early indications on the prospective payment system are that it appears to have encouraged substantial changes in the behavior of hospitals. Many of these changes are consistent with expectations, e.g., a deceleration in rate of increase for hospital expenditures, and decrease in average length of stay; but other changes, particularly the drop in Medicare admissions, were not anticipated. It is likely the full impact will not be felt until future years. Furthermore, the complex nature of the payment program, factored with the changing role of the hospital as a more competitive provider in the health care marketplace, brings about the need to consider refinements to the payment system.

STRATEGY: Section 603(a) of P.L. 98-21 and other legislation mandated a series of studies of impacts on and refinements to the prospective payment system. We will be coordinating a major intramural effort

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with extramural projects in order to continue to assess impacts and to develop these refinements. Additional research will be conducted to determine refinements to capital, medical education, and excluded hospital payment systems.

We will continue refinement of inpatient and outpatient hospital payment systems.

- Financial Impact of the Prospective Payment System and Other Payor Systems on Hospitals. We will continue to analyze the financial status of hospitals prior to and during the prospective payment system. The analyses will address the impact of the Medicare prospective payment system on different types of hospitals, with the analysis using such variables as hospital size, market share, occupancy rates, rural/urban status, teaching status, and disproportionate share status. We will also study the effect that private and public (non-Medicare) payors have on a hospital's financial status. We also plan on studying the impact of the prospective payment system on hospital revenues and resultant cost-shifting dynamics, particularly as they relate to the incidence and cost of administratively necessary days, facility conversions, patient transfers to swing beds or excluded units, and business arrangements for provider affiliations.

- Refinement of Specific Prospective Payment Factors. We will continue to address refinement of the current prospective payment system's outlier payment policy, systems which examine severity of illness within a given Diagnosis-Related Group, and other areas of potential refinement (such as development of a non-labor input price index).

- Analysis of Hospital Outpatient Care. We plan to continue studying the factors leading to the rapid growth in hospital outpatient costs. Specifically, we plan to conduct projects on the following issues:

    - Analyzing the increase in the volume and price of procedures provided in the outpatient department prior to and during PPS, with emphasis on clinical laboratory, radiology, and ambulatory surgical procedures; and

    - Studying the shift of Medicare cases from the inpatient to the outpatient department prior to and during PPS.

- Hospital Capital Payments. We will continue our analyses of appropriate capital payment policies related to decreases in hospital occupancy rates. We plan on continuing to analyze the capital investment patterns (including an analysis of interest, principal, and depreciation) of different types of hospitals on both a historical and a projected basis. We will continue to refine the HCFA hospital capital construction cost index. We also plan on studying how hospitals finance different types of investment.

- Rural Area Hospital Studies. We plan to continue and expand our efforts in research on alternative arrangements or systems involving hospitals in rural areas. Such studies will examine increasing competition between rural and urban facilities for physicians, nurses, and other health care professionals. We are also interested in developing a better understanding of how rural hospitals function, what can be done to assist them, and whether new types of facilities or services should be developed to replace or supplement them. Some areas of particular interest to us are:
    - Studies to examine the impact of PPS on access to care in rural areas. In particular, studies that examine changes in occupancy rate, DRG use, hospital referrals, patient transfers, and posthospital care since the inception of PPS.
    - Studies to examine the financial status of various classes of rural hospitals to identify those that have done well under PPS and those which have not and to determine the factors contributing to both.
    - Studies to examine the impact on access to care where rural hospitals have closed, including the effect on access by the elderly and the poor. The analysis of utilization patterns across providers in areas in which or near which a hospital has closed is also of great interest.

- Analyses of Hospital Case-Mix. HCFA has supported research and demonstration projects that would improve case-mix measurement and test alternative case-mix measurement systems for prospective payment of inpatient hospital care or other health care providers and test alternative case-specific payment systems for Medicare or other payors. We plan to continue to examine the impact of case-mix growth variation on different types of hospitals (for example, urban/rural hospitals, teaching hospitals, and large/small hospitals).

- Refinement of Specific Prospective Payment Factors. We plan to initiate studies that address refinement of the current prospective payment system, such as the outlier payment policy, systems that examine severity of illness within a given Diagnosis-Related Group, and other areas of potential refinement, (such as development of alternative non-labor input price adjustment).

- Refinements of Disproportionate Share Adjustment. Section 9105 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P. L. 99-369), requires the Secretary to pay an additional payment to hospitals that have a disproportionately high percentage of low-income patients. We plan on continuing our analyses to improve the disproportionate share" measurement and evaluate its financial impact on hospitals.

- Analysis of Medical Education Payments. We will continue studying the components of the Medicare direct medical education payment and possible ways to refine the current payment methodology. We will also continue to study the underlying factors that relate to the indirect medical education adjustment factor.

- Examination of Excluded Hospital and Excluded Unit Payment Methodologies. We plan to continue projects that would examine the pricing and patient volume characteristics of excluded hospitals and excluded hospital units to determine the appropriateness of alternative payment methodologies for these hospitals.

PROGRAM EFFICIENCIES, ANALYSES, AND REFINEMENTS

	FY 1989 Current	FY 1990 Budget Request
New Awards	$ 250,000	$ 1,019,878
Continuations	3,552,000	2,052,000
Total	$ 3,802,000	$ 3,071,878

GOAL: To further improve the knowledge and understanding of, as well as the ability to analyze, the impact of program changes and the factors influencing Medicare and Medicaid program performances. To better understand how the health care market has responded to legislative, regulatory, and technological changes in order to determine the necessity for further program changes.

RATIONALE: In the past 5 years, several legislative and regulatory changes have been implemented which have improved the effectiveness and efficiency of the Medicare and Medicaid programs. We are very interested in better understanding how the health care market has responded to these changes in order to determine the necessity for further policy reforms. Our research plan includes market analyses for clinical laboratory, durable medical equipment (DME), end-stage renal disease, ambulatory surgical center, parenteral and enteral nutrition, and ambulance services. In addition, we believe it is necessary to better understand the relationship between private sector employee retirement health plans and Medicare expenditures.

STRATEGY: Our efforts in this area are intended to gather data from external sources to supplement HCFA data sources in order to continue or initiate projects that focus on fundamental issues which relate to meeting program objectives.

- Clinical Laboratory Services. We plan to study the appropriateness of clinical laboratory payments. Areas of study include:

  - An analysis to determine the relationship between the resources used to perform clinical laboratory services and the actual Medicare payment for such services, including an examination of the impact of technological changes on the costs of clinical laboratory tests.

- A comparison of Medicare and private payor payments for clinical laboratory tests; large volume discounts and other special financial relationships should be explored.
- An analysis of the change in the volume of clinical laboratory services performed and an analysis of economies of scale for laboratory services.

o Durable Medical Equipment Services. We plan to study a number of durable medical equipment issues related to Medicare's current payment policies. Areas of study include the following:

  - An examination of the impact of recent legislative changes (e.g., OBRA 1987) on Medicare expenditures for durable medical equipment.
  - An analysis of Medicare's market share for major types of equipment.
  - A study comparing Medicare payment for durable medical equipment with other payors' payment systems.
  - An analysis of the extent to which Medicare expenditures for DME are reimbursed on a cost basis compared to DME provided by suppliers and reimbursed under Part B. This analysis should assist in examining how Medicare DME expenditures vary when similar equipment is furnished through different types of providers.

o Ambulatory Surgical Center Services. We plan to continue our study comparing the resource utilization for major surgical procedures in freestanding ambulatory surgical centers and outpatient hospital surgical centers. We will specifically analyze the market for cataract services, the largest ambulatory surgical service.

o Employee Retirement Health Plans. We plan to analyze the characteristics of private sector employee health plans for retirees over age 65. We will examine the extent to which these plans provide benefits for retirees in excess of the current Medicare package. The study will include an analysis of the effect that retiree health plans have on Medicare expenditures.

o End-Stage Renal Disease. We plan on continuing our research on the appropriateness of the current Medicare ESRD payment rates, particularly a congressionally-mandated study of the effects of reductions in payment rates on quality of and access to care. We plan on examining the resource requirements necessary to provide high quality care to ESRD beneficiaries. We also plan to continue studying selected technological and coverage issues to determine their impact on ESRD beneficiaries, including a congressionally-mandated study of the cost effectiveness of nutritional therapy in delaying the need for renal dialysis.

- Data Development and Other Projects. In addition to the continued refinements to selected Medicare and Medicaid program areas, we intend to continue our research effort designed to provide the information related to health care expenditures and utilization patterns of Medicare/Medicaid beneficiaries necessary to achieve more effective program operations. We will be continuing such major data development as the Medicaid Tape-to-Tape program, which will compile person-level encounter data by acquiring data on enrollment, utilization, expenditures and providers from 1985 through 1988.

BENEFICIARY AWARENESS AND PREVENTION

	FY 1989 Current	FY 1990 Budget Request
New Awards	$ 0	$ 200,000
Continuations	2,113,000	3,946,125
Total	$ 2,113,000	$ 4,146,125

GOAL: To test the cost-effectiveness of covering under Medicare and/or Medicaid such preventive services as immunizations, screening, testing, and health education services.

RATIONALE: There is a body of literature which indicates that spending for preventive health care services will reduce overall spending in the long run. Despite this evidence, Medicare, many State Medicaid programs, and other third-party payors cover few preventive care services.

STRATEGY: As a result of a special solicitation published in 1983 and a special solicitation for Medicare prevention demonstration sites published on May 29, 1987 (52 FR 20147) in response to section 9314 of P.L. 99-272, we plan to continue funding six projects designed to reduce disability and dependency through the provision of preventive health services. The five congressionally-mandated demonstrations funded as a result of P.L. 99-272 will be continuing through FY 1992. We will also be continuing the congressionally-mandated study of cost-effectiveness of providing influenza vaccine to Medicare beneficiaries.

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SUBACUTE AND LONG-TERM CARE

	FY 1989 Current	FY 1990 Budget Request
New Awards	$ 1,500,000	$ 700,000
Continuations	589,357	2,000,000
Total	$ 2,089,357	$ 2,700,000

GOAL: To study approaches that affect cost and quality of subacute and long-term care services for the Medicare and Medicaid programs. To participate with States and localities in identifying, developing, demonstrating, and evaluating effective alternatives to control the costs of long-term care reimbursement under the Medicaid program while maintaining a high quality of care.

RATIONALE: Various researchers have conducted initial descriptive efforts concerning the design of alternative payment systems, case mix methodologies, and other approaches that affect cost and quality of long-term care. We need to build upon the results of previous research to provide new knowledge or test innovative approaches to the cost-effective delivery of and payment for long-term care services. Medicaid is a principal source of funding for long-term care in the United States. In FY 1989, Federal expenditures for long-term care under the Medicaid program are expected to be over $14 billion. This represents nearly 50 percent of total Federal expenditures under the program in FY 1989. Furthermore, payments for long-term care are experiencing a more rapid rate of growth than payments for provision of other health care (i.e., hospital services and physician services), due in part to demographic trends.

The subacute home health and skilled nursing services under the Medicare program have undergone major changes over the past few years. These long-term care-related services will continue to warrant continued analysis with the expected legislation for catastrophic medical insurance coverage.

STRATEGY: In response to the increasing demands being made on the long-term care delivery and financing system, and to the move away from the traditional institutional approach toward caring for the needs of the elderly in the community, we believe the States' interest in taking actions aimed at furthering the mutual understanding of the characteristics and needs of the existing long-term care population require the development of alternatives to the existing reimbursement and delivery systems.

1. LONG-TERM CARE

- Long-Term Care Populations. We plan on continuing our studies of projects that focus on specific LTC populations such as Alzheimer's patients, AIDS patients, the institutionalized elderly, the mentally retarded and developmentally-disabled, or persons at risk of institutionalization because they have no family network.

- Acquired Immunodeficiency Syndrome (AIDS). We plan on continuing studies which determine the implications of AIDS for the Medicare and Medicaid programs. Specifically, we plan on studying the incidence and prevalence of AIDS, and the utilization and cost of services for the treatment of AIDS patients. We will analyze the inter-relationships between the various sources of payment for the treatment of AIDS patients, the extent of private insurance coverage and other third party payor coverage, as well as public sources of payment. We also plan on performing studies that help synthesize the many AIDS studies being conducted at local levels.

- Congressionally-Mandated Studies. We will be conducting studies related to the congressional mandates emanating from P.L. 99-509:

  - chronically mentally ill demonstration and evaluation (section 9412(a));
  - frail elderly demonstration and evaluation (section 9412(b));
  - multi-site demonstration in which families of Alzheimer's patients are offered respite and training in care-giving (section 9342).

- Refinements to LTC Financing System. We plan to continue projects for refining the financing of LTC services, including approaches that expand private risk-sharing for LTC costs, such as private LTC health insurance models, life care centers, and various State tax incentive programs.

- Spend-Down Population. We plan to continue our study of patients who spend down their resources and become Medicaid-eligible after admission to nursing homes, particularly the length of time involved in this spend-down process and the amounts and types of assets and resources that commonly are divested to spend down.

2. SUBACUTE CARE

- Home Health Care Utilization and Expenditure Patterns. Utilization and expenditures for home health care services vary widely across States. We plan to continue studying the differences in Medicare payment and utilization by geographic area, and how differences in market characteristics (demographics, numbers and types of providers, etc.) influence utilization of these services. We plan on performing time series analyses of Medicare's market share for these services.

CONGRESSIONAL MANDATES

As stated earlier, we estimate at this time (reflecting mandated studies from the Omnibus Budget Reconciliation Acts of 1986 and 1987, but assuming no new congressional mandates in FYs 1988-1990) that during FY 1990 we will spend $17 million for these projects. A breakout by priority area of congressionally-mandated activities follows:

o Quality and Effectiveness of Care	$4,560,000

- Reports on prospective payment system information on quality of post-hospital care (P.L. 99-509)
- Projects that study the impact of the Medicare prospective payment system on quality of care (P.L. 98-21)
- Projects that assess patient outcomes (P.L. 99-509)
- Study of quality of care provided to Medicaid beneficiaries (P.L. 99-509)
- Study of access to treatment and quality of care provided to the end stage renal disease population (P.L. 100-203)
- Study of quality of care/access to care in rural areas (P.L. 100-203)

o Physician Payment	$1,172,000

- Physician supply, utilization, and payment in rural areas (P.L. 100-203)
- Physician payment studies (P.L. 100-203)

o Alternative Payment Systems	$3,413,001

- Studies of HMO disenrollment and additional benefits through HMOs (P.L. 97-248)

  - Development of prospective payment methodology for outpatient hospital care and ambulatory care (P.L. 99-509)
  - Evaluation of the Social HMO Demonstration (P.L. 98-369 and P.L. 100-203)
  - Demonstration of a prospective payment system for home health services (P.L. 100-203)
  - Demonstration of a prepaid, capitated payment system for community nursing and ambulatory care furnished to Medicare beneficiaries (P.L. 100-203)
  - Continuation of demonstration project with the State of Arizona testing a statewide approach to cost effective health care financing (P.L. 100-203)

- Hospital Payment $2,347,000
  - Projects that will study the impact of the Medicare prospective payment system on beneficiaries and providers and which will assist in the refinement and extension of the PPS system as mandated by the Social Security Amendments of 1983 (P.L. 98-21), the Deficit Reduction Act of 1984 (P.L. 98-369) and the Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509)
  - Projects that will develop and assess refinement issues for severity of illness (P.L. 99-509)
  - Studies of the impact of PPS on rural health care (P.L. 100-203)
  - Development of a format for data collection under a uniform system for reporting by Medicare participating hospitals (P.L. 100-203)

- Program Efficiencies, Analyses, and Refinements $704,500
  - Research projects conducted under the small business innovation research program (P.L. 97-219)
  - Projects that study the efficacy and cost-effectiveness of nutritional therapy in treating chronic renal disease (P.L. 96-499)
  - Study of cost-effectiveness of provision of therapeutic shoes under Medicare (P.L. 100-203)

- Beneficiary Awareness and Prevention $3,346,125

  - Demonstration program to study reduction of disability and dependence through provision of preventive health services (Consolidated Omnibus Budget Reconciliation Act of 1985 and Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509))

  - Study of cost-effectiveness of provision of influenza vaccine under Medicare (P.L. 100-203)

- Subacute and Long Term Care $1,500,000

  - An evaluation of the chronically mentally ill demonstration mandated under section 9412(a) of P.L. 99-509

  - A study of a multi-site program in which families of Alzheimer's patients are offered respite and training in care-giving (P.L. 99-509)

  - An evaluation of the frail elderly demonstration mandated under section 9412(b) of P.L. 99-509

MEDICARE CONTRACTORS

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FY 1990

MEDICARE CONTRACTORS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

(Decision Unit MEDICARE CONTRACTORS
Budget Account 79-0511-0-1-550)

Analysis of Resources
(Dollars in Millions)

Total Program Level	FY 1988 Estimate	FY 1989 President's Budget	FY 1990
Total Obligations	$ 1,179.5	$ 1,391.0	$ 1,611.5
Contingency Fund	0.0	0.0	40.0
Notice of Utilization	2.1		
Total Resources	$ 1,181.6	$ 1,391.0	$ 1,651.5

Total Program Level	FY 1991	FY 1992	FY 1993	FY 1994
Total Obligations	$ 1,884.4	$ 2,192.9	$ 2,539.5	$ 2,942.1
Contingency Fund	40.0	40.0	40.0	40.0
Total Resources	$ 1,924.4	$ 2,232.9	$ 2,579.5	$ 2,982.1

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

MEDICARE CONTRACTORS

Authorizing Legislation-Social Security Act, Title XVIII, Sections 1816 and 1842, 42 U.S.C. 1395.

Purpose and Method of Operations

The Medicare contractors carry out the government's responsibility for reimbursing Medicare beneficiaries and providers of service in a timely, accurate, and fiscally responsible manner. Claims processing has become quite complex. Overall, Medicare contractors have implemented increasingly detailed legislation affecting claims processing activities in an effective and cost efficient manner. Also noteworthy is the fact that the growing, aging population and the corresponding increase in need for medical services cause Medicare claims to spiral. In FY 1990, outlays for Medicare's 34.2 million beneficiaries will be approximately $106 billion (Part A $62.3 billion and Part B $43.7 billion) with an estimated workload of 545.5 million claims. This represents an increase of 68.9 million claims over FY 1989. The Health Care Financing Administration (HCFA) has and will continue to implement policies designed to control costs through changes in payment methodology and aggressive efforts to control overutilization and detect fraud and abuse. The Medicare contractors are at the core of this dynamic environment and play a vital role in the processing of Medicare claims while preserving the fiscal integrity of the trust funds.

The cost for the Medicare contractors portion of administering the Medicare program is estimated to be $1,611.5 million in FY 1990, 1.5 percent of total Medicare outlays.

Intermediaries are responsible for reimbursement to providers of services under Part A of the Medicare program; such reimbursement covers primarily hospital inpatient activities. These responsibilities encompass making and accounting for Medicare benefit payments, auditing the financial records of providers, making final settlement of cost reports, recovering any Medicare overpayments, and safeguarding trust funds against payment for services that are not covered or medically necessary.

Carriers are responsible for adjudicating claims and making payments to beneficiaries and providers of service under Part B of the Medicare program. Reimbursement covers primarily physician services. These responsibilities include receiving and accounting for Medicare benefit payments, accounting for payments made directly to and/or on behalf of eligible Medicare beneficiaries, determining allowable reasonable charges for covered services, computing and recovering overpayments in cases of erroneous payment, implementing the participating physician program and establishing methodologies to identify utilization patterns which deviate from medically accepted norms and bringing such patterns to the attention of the appropriate professional groups.

Intermediaries and carriers provide information, guidance and technical support to both providers of service and beneficiaries on the administration of the Medicare program. The costs incurred by the intermediaries ($572.5 million) and carriers ($1,039.0 million) in fulfilling their respective responsibilities in FY 1990, are reflected in the Medicare contractor budget request.

HCFA currently negotiates 88 contracts with intermediaries and carriers, including three experimental fixed-price contracts. HCFA is responsible for monitoring all of these contractors' expenditures, tracking savings realized from payment safeguard activities, and reviewing contractor performance in paying claims, serving Medicare beneficiaries and assuring the fiscal integrity of the Medicare Trust Funds.

Highlights

Medicare Claims Payment Timeliness

Over the past 3 years, Congress has prescribed several specific policies for the timely payment of claims. The Omnibus Budget Reconciliation Act (OBRA) of 1986 provides controls on claims processing time ceilings. These ceilings are 95 percent of clean claims to be paid in not more than 30 days in FY 1987; 26 days in FY 1988; 25 days in FY 1989; and 24 days in FY 1990 and beyond. In addition, OBRA 1986 requires that beginning in FY 1988, participating physicians be paid 7 days earlier than the standard for other physicians.

Common Working File (CWF)

In FY 1988, HCFA successfully piloted two CWF projects. The CWF combines Part A and Part B beneficiary data in an on-line realtime environment for use by carriers and intermediaries. It creates a series of database hosts containing all beneficiary entitlement, utilization and claims history data. In FY 1990, HCFA will complete the nationwide network of common working files. HCFA will use the CWF to facilitate administration of the catastrophic health insurance program proposed by the Administration. The total estimated program savings from the CWF in FY 1990 is expected to be $62.5 million.

Carrier Medical Review FY 1990

The carrier medical review process will continue to be strengthened in FY 1990 in four broad directions. Prepayment medical review will be intensified by mandating a number of new cost effective screens and focusing on high dollar and frequently performed services. The postpayment review focus will be strengthened by increasing the level, i.e., percentage, of review, and requiring carrier review of physicians with significant Medicare income increases, as well as physicians that order excess tests. Enhanced analysis of Part B data will be emphasized to identify potential areas for focusing utilization review efforts. A number of new review techniques are being tested by carriers in FY 1988 and 1989. Those that prove effective will be implemented nationwide in FY 1990.

Standard Systems

HCFA has funded the development of standard claims processing systems to reduce the cost and risk inherent in systems changes. Standard systems are now used by 31 percent of the contractors. Expansion of the standard systems will continue in FY 1989 and FY 1990 with particular emphasis on the Part B standard system that was developed in FY 1988.

Medicare Secondary Payer (MSP)

In FY 1989 and FY 1990 we will intensify our effort to identify those situations in which Medicare is not the primary payer before payment is made. We will do this by increasing our exchanges with governmental agencies and by enhancing our Regional Data Exchange System.

In FY 1989 we will implement a new regulation that will make Medicare the secondary payer to all forms of no-fault insurance. This effort is expected to cost nearly $8 million in FY 1990, with the resultant savings of $50 million.

Provider Services (Increased Professional Relations)

The success of the Medicare program depends upon the continuing cooperation of individuals and institutions providing health care services. Funding will allow carriers to send newsletters to physicians and suppliers which address changes before they are implemented. Physician/supplier office staff will obtain status information and reimbursement and coverage information more easily. Carriers will provide basic training on claims submission as well as indepth training for experienced office staff on claims processing requirements in specific situations. Carriers will make training available to physician/supplier office staff several times a year because many offices have a high turnover rate.

Beneficiary and Provider Services

To enhance the quality of service rendered to Medicare beneficiaries and providers, HCFA has budgeted $87.7 million for reconsiderations, and hearings, and $95.0 million for beneficiary communications in FY 1990. The 20 percent increase over the President's FY 1989 budget will cover costs associated with increased hearing and reconsiderations workloads (from 7.0 million in FY 1989) projected to reach 9.0 million in FY 1990. This level of funding will also cover timely implementation of OBRA requirements that contractors: (1) process 75 percent of Part A reconsiderations in 60 days; (2) 90 percent of Administrative Law Judge hearings in 90 days; (3) 95 percent of reviews in 45 days; and (4) 90 percent of Part B hearings within 120 days. The monies will also enable HCFA to effectively and efficiently process the 31.9 million beneficiary and provider inquiries (written, telephone, and walk-in) expected to be generated over the course of FY 1990.

Printing

Funds for printing the Medicare Handbook are now included under Printing at a projected cost of $3.1 million in FY 1990. This action results from the transfer of the Medicare Handbook printing function from another agency to HCFA.

MEDICARE CONTRACTOR BUDGET
FY 1990
(Dollars in Millions)

	FY 1988 CURRENT ESTIMATE	FY 1989 PRESIDENT'S BUDGET	FY 1990 REQUEST
PAYMENT SAFEGUARDS			
Medical Review/Utilization	$ 116.9	$ 201.6 1/	$ 224.
Audit	120.4	138.1	151.
Medicare Secondary Payer	62.8	69.0	76.
Total Payment Safeguard	$ 300.1	$ 408.7	$ 452.
PRODUCTIVITY INVESTMENTS	$ 54.9	$ 50.3 2/	$ 77.
CLAIMS PROCESSING			
Bill/Claims Payment	$ 574.8	$ 622.5	$ 723.
Reimbursement	30.5	33.9	38.
Printing	2.3	2.5	5.
Fixed Price Contracts	44.9	80.5	83.
Total Claims Processing	$ 652.5	$ 739.4	$ 850.
BENEFICIARY & PROVIDER SERVICES			
Hearings	$ 66.1	$ 68.7	$ 87.
Beneficiary Communications	78.7	83.5	95.
Professional Relations	0.0	9.3	16.
Total Beneficiary & Provider Services	$ 144.8	$ 161.5	$ 198.
PARTICIPATING PHYSICIANS	$ 27.2	$ 31.1	$ 32.
TOTAL OPERATING FUNDS	$1,179.5	$1,391.0	$1,611.
CONTINGENCY	$ 0.0	$ 0.0	$ 40.
TOTAL CONTRACTOR BUDGET	$1,179.5	$1,391.0	$1,651.
NOU (Transferred from SSA)	$ 2.1		

1/ Includes $5.6 million for fraud and abuse activities in FY 1989.

2/ The President's Budget amount was $65.4 million. We have made the following changes: transferred $2.8 million for NOUs to Claims Processing to be included in the unit cost of claims; eliminated $3 million special payment for EMC and included it in the unit cost; and transferred $9.3 million from PIs to Beneficiary and Provider Services due to the nature of ongoing functions.

Rationale for the Budget Request

I. Payment Safeguards

In addition to processing and paying claims for providers of service and Medicare beneficiaries, contractors perform other very vital functions. These functions include conducting medical review of claims to ascertain whether services are medically necessary and constitute an appropriate level of care, the auditing of Medicare cost reports of providers, and assuring that under certain circumstances, Medicare is the secondary payer (MSP) if a beneficiary's services are covered by private insurance. These medical review, audit and MSP activities are referred to as Payment Safeguards. HCFA has implemented a system for continued verification of the savings reported by contractors.

A. Medical Review/Utilization Review

- Intermediary Medical Review

Fiscal intermediaries (FIs) are responsible for medical review of services delivered in other than an inpatient acute care setting; e.g., outpatient, home health agency (HHA), skilled nursing facility (SNF), etc. This review assures that the medical care provided is a Medicare covered service and is necessary and appropriate.

In FY 1990, HCFA will continue to increase mandated screens on prepayment review. Added emphasis will be given to identifying aberrant patterns and utilizing prepayment screens to focus review on areas of potential abuse and overutilization. In addition, postpayment compliance reviews will be intensified for providers reflecting aberrant patterns of utilization.

Intermediaries will be encouraged to utilize specialty professionals to review specialty areas and to educate staff. Intermediary medical review costs will increase from $74.9 million in FY 1989 to $84.4 million in FY 1990. The $9.5 million increase is caused by a 11.5 percent increase in claims volume and inflation of 3.7 percent. HHA compliance reviews will increase by 5 percent, other types of reviews will increase from 10 percent to 15 percent. Outpatient and SNF reviews remain unchanged from previous levels. By focusing review on specific areas HCFA anticipates approximately $400 million in savings in FY 1990.

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o Carrier Medical Review

In FY 1990, HCFA plans to continue expanding prepayment review. HCFA will develop and implement additional medical review screens during FY 1990 and maintain the increased level of medically trained carrier professionals established in FY 1989. HCFA also plans to continue to focus on high dollar and frequently performed services, utilizing Part B Medicare Data (BMAD) as a major source of information.

During FY 1990, HCFA will also refine the postpayment medical review selection process. The carrier postpayment process consists of profiling physicians, providers and beneficiaries, identifying patterns of overutilization, excessive testing, fraud and abuse, correcting such program abuse or overutilization, preventing further excess by educating providers in acceptable norms and proper billing practices, recommending punitive action where appropriate, and identifying areas for the development and installation of future prepayment review screens.

HCFA will require carriers to strengthen their professional consultation in the development of medical review policy. HCFA will conduct periodic meetings of carrier medical directors to enhance uniformity in medical review policy development. Carriers will have in place a physician communication system that ensures all new and revised policies are appropriately disseminated prior to their implementation.

In order to carry out this agenda of carrier medical review, designed to address overutilization of services and the resultant impact on program expenditures, carrier medical review costs will increase from $126.7 million in FY 1989 to $140.0 million in FY 1990. HCFA anticipates approximately $1.1 billion in savings in FY 1990.

B. Provider Audit

In FY 1990, the audit of provider cost reports will continue as a major payment safeguard initiative. Program payments for institutional services to Medicare beneficiaries are expected to be $80 billion by FY 1990, and the audit of provider cost reports is the primary instrument with which the integrity of these funds is maintained. Historically, the audit process has recovered millions of dollars in improper program payments each year. In FY 1988 and FY 1989 HCFA expects to achieve savings of $840 million and $820 million, respectively. In FY 1990 we expect to achieve audit savings of $917.0 million.

In addition, audit procedures will be performed to address issues introduced by recent legislation. These issues include disproportionate share payments, indirect and direct medical education costs, return on equity capital for inpatient services, wage index surveys, electronic hospital cost reporting, and the hospital cost report information demonstration.

- Medicare Provider Growth

The growth rate in the number of Medicare providers varies significantly, by type of provider. HHAs have shown a consistent 2 percent annual growth rate, while SNFs increase at a rate of 3 percent per year. Data also show that while the overall number of hospitals has remained constant, there is a steady increase in the number of multi-facility providers under PPS, i.e., more providers with excluded units and/or subproviders which are exempt from PPS.

This trend indicates that there is an increasing portion of provider costs which are reimbursed on a cost basis. In fact, our most recent payment data indicate that amounts paid to non-PPS providers, in addition to the cost portion of payments to PPS providers, represent 40 percent of total payments to providers. Thus, a considerable amount of audit effort is warranted to verify the cost based reimbursement. This is further evidenced by the fact that hospital audits in FY 1987 produced a return of $11 for every dollar spent on audit.

- Audit Priorities

Considering the provider growth and the increase in cost based reimbursement, we will continue to prioritize the audits of PPS multi-facility hospitals as well as chain-affiliated providers. In addition, by concentrating our efforts on HHAs and SNFs which meet our minimum audit criteria, we will maximize the potential savings in these areas. We will also focus our audit efforts on costs reported and allocated by home offices, since there are numerous incentives for chain home offices to maximize reimbursement through cost allocation practices.

C. Medicare Secondary Payer (MSP)

In FY 1988, contractors continued to identify situations for which other payers were primary to Medicare. Contractors review all claims as they are submitted to ascertain if the beneficiary has other health insurance coverage. Such coverages include the working aged, the disabled, workers' compensation, end stage renal disease and auto liability/no-fault insurance. The identification of potential other coverage is based on development of claims, data exchange systems among contractors, and indications of earnings from Social Security Records.

Contractors determine if other coverage is applicable before making payment. If Medicare is the secondary payer, payment is avoided or reduced. If Medicare has initially made the primary payment and subsequently learns that it is the secondary payer, the contractors institute recovery action.

In FY 1989 and FY 1990, HCFA will intensify its efforts to identify, cost avoid, and recover payments for which other insurers are the primary payers. We will improve our identification process by enhancing our Regional Data Exchange System, increasing our data exchanges with other governmental agencies, and improving our educational efforts to beneficiaries, employers, insurers, and providers. All these activities will increase the proportion of claims identified as having MSP involvement which in turn will require more intense development and recovery effort on the part of the Medicare contractors.

In FY 1989 we will implement a new regulatory provision that will make Medicare the secondary payer in all forms of no-fault insurance. This provision is expected to increase our MSP savings by more than $50 million annually. After an implementation cost of $2 million, this effort is expected to cost over $7 million in FY 1989 and nearly $8 million in FY 1990.

Payment Safeguard Administrative Costs and Deferrals/Savings ($ in Millions)

	FY 1988		FY 1989		FY 1990	
	Admin. Costs	Deferrals Savings	Admin. Costs	Deferrals Savings	Admin. Costs	Deferrals Savings
Medical Review/ Utilization Review						
Part A	$ 51.7	$ 229.1	$ 74.9	$ 358.5	$ 84.4	$ 400.0
Part B	65.2	560.0	126.7	975.0	140.0	1,100.0
Audit						
Part A	$ 120.4	$ 840.0	$ 138.1	$ 820.0	$ 151.3	$ 917.0
Medicare Secondary Payer						
Part A	$ 31.5	$ 975.0	$ 44.0	$ 1,016.9	$ 48.8	$ 1,070.0
Part B	31.3	279.0	25.0	291.0	27.5	343.5
TOTAL	$ 300.1	$ 2,883.1	$ 408.7	$ 3,461.4	$ 452.0	$ 3,830.5

II. Productivity Investments - $77.5 Million

A description of each proposed initiative follows:

Common Working File (CWF) - $42.9 Million

The CWF initiative improves Medicare claims processing by creating a set of localized databases (hosts) containing all beneficiary entitlement, utilization, and claims history data. This decentralized claims validation and benefit authorization process has an extremely high potential for reducing erroneous payments, and thereby saving significant amounts of program funds. By requiring that all contractor claims be validated against this database prior to payment, HCFA expands MSP recoveries, reduces overpayments due to conflicting Part A and Part B claims and reduces duplicate payments. Part A providers are given on-line access to basic beneficiary data, thereby significantly improving the quality of submitted bills. In addition, contractor costs are reduced through elimination of error prone processes such as A/B data exchange, UNIBILLs and payment records.

Finally, CWF creates a real-time database in Baltimore for program policy studies and support of Congressional requests, while eliminating most contractor costs for BMAD. In FY 1990 HCFA will complete CWF implementation. All contractors will then be connected to the hosts and their own operating systems altered to automatically incorporate the enhanced edit and program safeguard data from the CWFs. The CWF project will produce program savings while significantly modernizing claims operations at the contractors and within HCFA. The total estimate of program savings for FY 1990 is $62.5 million through implementation of A/B data match edits, elimination of the $50 payment record reject tolerance, savings of interest lost to the Trust Fund due to uncollected deductibles and coinsurance, faster and more elaborate MSP identification, and implementation of medical review screens.

Contracting Strategy - $9.1 Million

Under Section 2326 of DEFRA, the Secretary was given the authority to replace poor performing contractors which ranked, over time, in the lowest 20th percentile as measured by the Secretary's cost and performance criteria. Also under Section 222 of Public Law 92-603, the Secretary has the authority to enter into experimental fixed-price contracts. The Secretary may also find necessary and/or advisable to change or consolidate workloads. Use of these authorities strengthens and improves Medicare contractor operations. In removing the contractors from participation in the Medicare program, HCFA will incur transition and termination costs.

Standard Systems (Part A and Part B) - $6.0 Million

The high degree of volatility in Medicare program requirements, driven by new legislation and program enhancement efforts, requires contractors to constantly modify their claims processing systems. This process is time consuming and systems maintenance is costly. To reduce the time and costs, HCFA has developed and promoted standard claims processing systems. These efficiencies are achieved through shared maintenance arrangements in which contractors pool funds for joint maintenance staffs. This results in larger and more competent systems staffs, faster and higher quality responses to HCFA mandates, and additional staff to work on general systems tuning and upgrades. The use of standard systems establishes a greater degree of uniformity among contractors' claims processing and program safeguard applications. Standard systems also significantly reduce the risks of replacing contractors' operations. At present, there are 27 standard system users. Promotions of standard systems will continue in FY 1990 with particular emphasis on expanding use of the Part B Standard System developed in FY 1988.

Quality Control Initiatives - $3.9 Million

All intermediaries and carriers are required to operate their claims processing systems in an efficient manner that assures accuracy. In FY 1990, contractors will conduct Part A and Part B operational reviews of policies and operational issues to identify any problem which must be corrected. We will also measure the accuracy of FIs' PPS bill processing operation and reduce incorrect program payments through the identification and resolution of deficiencies. In addition, we will perform a major programming overhaul of the Part B quality assurance (QA) system. This system is used to measure the accuracy of carrier claims processing performance. The Part B QA initiative provides a data base for analysis, more efficient sampling, and more timely transmission of data to HCFA from the carriers. We will also complete implementation of reasonable charge screen edits in FY 1990. These edits will improve the accuracy of carriers' reasonable charge computations in FY 1990.

Home Health Agency (HHA) Data Base - $3.0 Million

No database currently exists which combines billing and medical information on home health services. Building a HHA database will provide uniform data for home health service utilization review. The use of the data will improve medical review by permitting the intermediary to focus on aberrant patterns.

Physician Identification - $2.4 Million

The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 requires that HCFA establish a unique physician identifier for each of the approximately 600,000 physicians and limited licensed practitioners who provide services for which Medicare payment is made. The file will become operational in FY 1989. In FY 1990, $2.4 million is needed to maintain the physician ID file and to accrete/update an estimated 30,000 physicians and practitioners to the system.

Systems Security and OIG Studies - $2.3 Million

Contractors are required by the Office of Management and Budget (OMB) to meet minimum standards for systems and data security to protect the confidentiality of beneficiary and provider records. The systems security requirement of the Privacy Act is set forth in OMB Circular A-71. Based on a risk analysis, contractors are expected to implement or update appropriate administrative, technical and physical safeguards to comply with OMB requirements. Additionally, the Inspector General identifies enhancements to contractor systems security during audits. Such enhancements and HCFA mandated changes would be funded through this productivity investment.

Durable Medical Equipment (DME) - $2.0 Million

In FY 1990, HCFA will pilot an expansion of history files at selected carrier sites. Selected carriers will require more complete rental/purchase information from suppliers and ordering physicians on claims submitted for payment in order to test strengthened payment safeguards.

HCFA - 1500 Revision - $1.5 Million

The use of the standard HCFA-1500 Health Insurance Claim Form is required by regulation. HCFA has worked closely with the AMA, HIAA, Blue Cross and Blue Shield Association (BCBSA), State Medicaid and other Federal agencies to develop such a form and expects a revised HCFA-1500 that improves the coordination of benefits to be approved in FY 1989. Carriers will have to make limited systems changes to accommodate the new claims form and educate physicians on the use of the new form. The use of the revised form will improve program efficiency, permit optical scanning, improve Medicare Secondary Payer operations, and will improve claims, coding and reimbursement data.

Resolution of Court Judgments - $1.4 Million

Contractors must take actions to meet court judgments resulting from lawsuits. One such lawsuit (Fox vs Bowen) involves the processing of skilled nursing facility claims for physical therapy previously denied in Connecticut.

Beneficiary Initiatives - $2.0 Million

In a continuing effort to improve the quality and readability of information furnished to over 30 million Medicare beneficiaries, funds are requested for contractors to implement changes to format, design, and readability of information, as well as to improve and implement Explanation of Medicare Benefit (EOMB) messages.

Facilities Management - $1.0 Million

Three facilities management (FM) subcontracts will expire in FY 1990. These subcontracts are needed to handle Medicare data processing functions and must be recompeted at an estimated cost of $1 million.

PRODUCTIVITY INVESTMENTS
INTERMEDIARIES
($ in Millions)

Proposal	Amount Requested FY 1989	Amount Requested FY 1990
Common Working File	$ 4.6	$ 21.4
Contracting Strategy	3.9	5.7
Home Health Agency Data Base	0.0	3.0
Standard Systems	6.0	3.0
Resolve Court Judgments	0.0	1.4
Systems Security/OIG Studies	0.9	1.1
Facilities Management	0.0	0.5
Quality Control Activities	0.0	0.4
Pacemaker Registry	0.8	0.0
Contractor Data Exchange	2.4	0.0
Total Intermediaries	$ 18.6	$ 36.5

PRODUCTIVITY INVESTMENTS
CARRIERS
($ In Millions)

Proposal	Amount Requested FY 1989	Amount Requested FY 1990
Common Working File	$ 3.4	$ 21.5
Quality Control Activities	0.0	3.5
Contracting Strategy	2.0	3.4
Standard Systems	4.0	3.0
Physician Identification	6.0	2.4
Beneficiary Initiatives	1.7	2.0
Durable Medical Equipment	0.0	2.0
Revised Form HCFA-1500	0.0	1.5
Systems Security/OIG Studies	0.8	1.2
Facilities Management	0.0	0.5
Certified Registered Nurse Anesthetists	1.2	0.0
Contractor Data Exchange	6.4	0.0
Reconciliation Provisions	6.2	0.0
Total Carriers	$ 31.7	$ 41.0
TOTAL ALL CONTRACTORS	$ 50.3 1/	$ 77.5

1/ This amount is $15.1 million less than the President's Budget due to the removal of $3 million for EMC marketing efforts, and the transferral of $2.8 million (NOU) to Claims Processing for inclusion in the unit cost of claims and $9.3 Professional Relations to Beneficiary and Provider Services as a separate line item.

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III. CLAIMS PROCESSING

A. Claims Payment - $723.9 Million

Contractors must determine whether services for which claims are received are covered, whether the patient is entitled to benefits, and the amount of payment. These activities, along with the medical review and MSP activities, must be performed with a high degree of accuracy within 24 days of receipt of the bill (17 days for a participating physician bill).

Claims payment includes direct and indirect costs associated with the receipt, processing and payment of Medicare claims. These costs include labor, ADP, and administrative support activities for cost contractors only.

Claims payment also includes $9.4 million for other ongoing costs such as freedom of information, GAO special studies, Rural Health Clinics, and BCBSA expenses. These costs are not applicable to the unit cost calculation.

The following factors increase/decrease claims payment costs in FY 1990.

Factor	Increase/Decrease ($ in millions)
Volume of Claims	$ 80.5
Inflation	25.3
Postage	11.5
Lawsuits	8.0
OBRA 1987 Provisions	3.9
Market Price Savings	(15.0)
Savings from Pricing Incremental Workload @ 90 percent	(8.8)
Transfer of Facilities Management To Productivity Investments	(4.0)
	$101.4

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FACTORS IMPACTING WORKLOAD AND UNIT COST

We consulted the actuary in determining workload projections for FY 1989 and FY 1990. Using a statistical forecasting analysis of the latest available actual workload data, we developed workload estimates for FY 1989 and FY 1990. We project an increase of 5.0 percent for Part A and 9.3 percent for Part B between FY 1988 and FY 1989. We also project additional workload growth in FY 1990 of 11.5 percent in Part A and 15.0 percent in Part B.

Inflation is assumed to be 3.7 percent which is consistent with the latest Office of Management and Budget CPIW economic indicators.

In accordance with section 4031(a)(B)(ii) of OBRA 1987, we have requested funds for the 14-day payment floor. Section 4031(b) prohibits the Secretary of Health and Human Services from issuing, "after the date of enactment of this Act, and before October 1, 1990, any final regulation, instruction, or other policy change which is primarily intended to have the effect of slowing down claims processing, or delaying payment of claims, under title XVIII of the Social Security Act." Since the Secretary is not authorized to change the 14-day floor provision prior to October 1, 1990, we have budgeted for its continuation at a cost of $22.4 million.

For cost contractors, the claims payment unit cost is derived by dividing the contractors' claims payment and hearings costs for Part A and their claims payment, hearings, and beneficiary communications costs for Part B by the corresponding bill/claims workload. By definition, unit costs are not derivable for fixed-price contractors.

The following tables show unit cost data and workload receipts for FYs 1985 through FY 1987 and projections for receipts for FYs 1988 through FY 1990.

Unit Cost (Lines 1 - 3)

	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990
Cost Contracts:						
Part A	$2.33	$1.97	$1.81	$1.98	$2.17	$2.24
Part B	$1.88	$1.72	$1.65	$1.59	$1.66	$1.77

Workload Receipts in Millions

	FY 1985	FY 1986	FY 1987	FY 1988	FY 1989	FY 1990
Part A						
Cost Contractors	51.2	55.1	59.2	68.9	70.7	78.7
% Change		7.6	7.4	16.4	2.6	11.3
Fixed Price	8.4	8.9	8.0	1.6	3.3	3.8
% Change		5.6	-10.0	-80.0	106.3	15.1
Total	59.6	64.0	67.2	70.5	74.0	82.5
% Change		7.4	5.0	4.9	5.0	11.5 1/
Part B						
Cost Contractors	255.6	285.4	318.3	350.7	359.1	413.1
% Change		11.7	11.5	10.2	2.4	15.0
Fixed Price	15.2	14.9	15.8	17.5	43.5	49.9
% change		-2.0	6.0	10.8	108.6	14.7
Total	270.8	300.3	334.1	368.2	402.6	463.0
% Change		10.9	11.3	10.2	9.3	15.0 1/

1/ The FY 1990 percent of increase is substantial because the original projections for FY 1989 were significantly understated.

B. Other Related Costs

In addition to claims payment expenses, Medicare contractors incur other costs that are related to the processing of claims. Some of the costs are incurred only by intermediaries, some are incurred only by carriers, and some are incurred by both.

Costs Incurred by Intermediaries Only

- Reimbursement - $38.1 million - In FY 1990 Medicare contractors will provide reimbursement services based on 25,145 health care providers. This represents an increase of 6.2 percent over the number of providers requiring reimbursement services in FY 1989. Reimbursement services are required by Medicare regulations. They include the following activities:

  - Collection of Provider Overpayments - Systems will be maintained to record overpayments made to providers and their collection. In addition, uncollectible overpayment cases will be investigated and profiled for litigation.

  - Interim Payments - Interim payment rates for all Medicare providers will be reviewed and adjusted throughout the fiscal year. This process requires the review of provider cost and utilization statistics and the calculation of adjusted rates.

  - Consultative Services - Onsite assistance will be provided to any provider experiencing difficulties in preparing the cost report, preparing claims, or any other reimbursement area.

  - Records and Reports - According to specific instruction, files and records will be maintained to ensure proper payments to providers. Several different statistical reports will be prepared and submitted to HCFA on an ongoing basis.

  Also included in the Reimbursement budget for FY 1990 are the costs associated with the following initiatives.

  - Adjustment of Hospital Specific Payment Rates - In accordance with the court decision, hospital specific prospective payment rates will be recalculated and adjustment payments issued to providers with successful appeals of base period cost reports. Hospital specific rates will also be recalculated in accordance with negotiated agreements for labor/delivery room and malpractice insurance. Cost $2.1 million.

- System Tracking for Audit and Reimbursement (STAR) The STAR system will be modified to collect a greater volume of audit and reimbursement data. Funds will be used for additional computer hardware, software changes, and upgraded communication systems. Cost is $1.2 million.

- Periodic Interim Payments (PIP)-In accordance with Section 9311(a) of OBRA 1986, intermediaries will be performing an increased number of PIP interim rate reviews for qualifying providers. This increase is not reflected in the FY 1989 budget. Cost $.6 million.

- Home Health Agency/Hospice Transition - The transition of provider-based home health agencies and hospices to regional intermediaries will require the ongoing transmission of audit and reimbursement data between intermediaries. Cost $.3 million.

Costs Incurred by Carriers Only

o Administration of the Medicare Participating Physician and Supplier Program - $32.3 million

The Medicare Participating Physician and Supplier Program (MPPSP) was established by the DEFRA of 1984 and modified by each subsequent budget reconciliation act. The main goal is to reduce the impact of medical costs upon beneficiaries by establishing incentives for physicians and suppliers to accept assignment on all Medicare claims. The incentives include: a higher prevailing charge for participating physicians; distribution of a directory (MEDPARD) of participants to beneficiaries, senior citizen organization, and hospitals; toll free telephone lines available to beneficiaries to locate participants; information on MPPSP on each EOMB for a non-assigned claim; direct lines for the submission of electronic claims; and faster payment of claims. MPPSP also provides disincentives for non-participation: a limit on Maximum Allowable Actual Charges (MAAC); the disclosures by non-participating physicians of beneficiary costs for elective surgery costing more than $500; and prohibition against billing for unassigned services which were determined to be medically unnecessary. Physicians and suppliers must be offered an opportunity to initiate or cancel a participation agreement annually.

Carrier funding for MPPSP includes such tasks and activities as: mailing an annual participation enrollment package to each physician and supplier;

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printing and distributing MEDPARDS; maintaining toll-free beneficiary telephone service for participation information; direct EMC lines; monitoring compliance with the MAAC limits; and monitoring compliance with the elective surgery disclosure requirement.

Carriers are encouraged to develop innovative measures to increase the number of participants in their jurisdiction. Included in the $32.3 million is $5.0 million to administer the OBRA 1986 provision for carrier bonuses.

- Professional Relations - $16.2 Million - The success of the Medicare program depends upon the continuing cooperation of individuals and institutions providing health care services. Funding will allow carriers to send newsletters to physicians and suppliers which address changes before they are implemented. Physician/supplier office staff will obtain status information and reimbursement and coverage information more easily. Carriers will provide basic training on claims submission as well as indepth training for experienced office staff on claims processing requirements in specific situations. Carriers will make training available to physician/supplier office staff several times a year because many offices have a high turnover rate.

- Beneficiary Communications - $95.0 Million - The Medicare program is complex, based on many provisions required by law, regulations and policy dealing with entitlement, coverage of services and limitations on coverage of services, comprehensive payment rules, and the rights and responsibilities of beneficiaries. Contractors are the direct link between beneficiaries and the program. This activity includes all costs related to beneficiary inquiries (an estimated 31.9 million in FY 1990) generated by means of telephone, correspondence, and walk-ins. The FY 1990 increment for this function is $11.5 million and results from inflation and increased workload.

Costs Incurred by All Contractors

- Hearings and Reconsiderations - $87.7 Million - This function includes all activities related to due process as a result of contractor disallowances of bills or claims. Beneficiaries, providers, and physicians are entitled under the law to request reconsiderations or formal reviews and hearings if they are dissatisfied with initial payment determinations made by contractors. Associated costs include all activities related to formalized hearings and appeals such as legal fees, recording fees, travel, and other incidental charges and walk-ins. In FY 1990, the hearings and reconsideration workload will reach 9.0 million. The FY 1990 increment for this activity is $19.0 million. The increase is a result of inflation, increased workloads produced by OBRA 1986, Section 9313, and OBRA 1987, Section 4082 which requires that contractors process 75 percent of Part A reconsiderations in 60 days and 90 percent of Administrative Law Judge hearings in 90 days. OBRA 1987 also requires that contractors process 95 percent of reviews in 45 days and 90 percent of the Part B hearings within 120 days.

- Printing - $5.3 million - In the interest of maintaining standard formats and quality of Medicare entitlement and report forms, HCFA supplies beneficiary enrollment and provider cost reporting forms. The use of these forms is essential to beneficiary notification, effective and efficient contractor operations, and other program purposes. We have decreased our base printing costs for FY 1990 by $300,000 which represents the removal of the survey and certification forms from this function.

  In FY 1990 HCFA will assume full responsibility from SSA for printing and distributing the Medicare handbook. The handbook gives the Medicare beneficiary the official statement of program coverage and rules. A copy of the new booklet is sent to each new enrollee and copies are available, by request, at carrier, intermediary, and Social Security offices. Six million handbooks will be distributed in FY 1990. Funds for this activity are included at a projected cost of $3.1 million.

C. Experimental Fixed Price Contracts - $83.5 million

Section 222 of Public Law 92-603 gives HCFA the authority to experiment with reimbursement to Medicare contractors for services rendered on other than a cost basis. The experimental contracts currently in force are in the fixed-price category. These contracts are awarded for a specific period of time, and the total price changes only through contract modifications to pay for additional work not included in the original contract terms. In FY 1990 we will continue the FY 1989 level (adjusted for inflation) of fixed price contracts.

V. CONTINGENCY FUND

A contingency fund is normally requested to permit funding for workload or operating costs not anticipated at the time the budget is formulated. Examples of such costs are those needed to meet greater than budgeted workloads (claims, reconsiderations, reviews, hearings, inquiries, etc.), unanticipated inflation growth, court judgments, postal rate increases, and any other unanticipated changes. In FY 1990, HCFA is requesting a contingency fund of $40.0 million for the Medicare contractor budget.

STATE CERTIFICATION

FY 1990

STATE CERTIFICATION

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Decision Unit - STATE CERTIFICATION
(Budget Account - 75-0511-0-1-550)

Analysis of Resources
(Dollars in Thousands)

Total Program Level	FY 1988 Appropriated	FY 1989 President's Budget	FY 1990 Request
Total Obligations	$65,859	$65,859	$99,113
Less Trust Funds Transfers	-57,922	-62,235	-92,555
Total Budget Authority	$ 7,937	$ 3,624	$ 6,558

Total Program Level	FY 1991	FY 1992	FY 1993	FY 1994
Total Obligations	$102,582	$105,659	$108,195	$110,792

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
MEDICARE STATE CERTIFICATION

Authorizing Legislation - Social Security Act, Title XVIII, Section 1864.

Purpose and Method of Operations

The purpose of the State Certification program is to ensure that institutions and agencies providing health care services to Medicare and Medicaid beneficiaries meet Federal standards for health quality and safety. The State administered Medicaid survey and certification program is also provided funding and oversight by the Health Care Financing Administration (HCFA). Federal financial participation for this activity is included in the Grants to States for Medicaid account.

The State Certification program has been in existence since 1966 and initially covered hospital inspections. With the growth of the health care industry since then (both in services and facilities), Medicare and Medicaid coverage has expanded to include numerous types of providers and suppliers. This increase in providers and suppliers has expanded program activity from inspection of a few thousand hospitals in 1966 to required oversight of approximately 46,447 diverse health care providers and suppliers by FY 1990. As a result of implementation of the prospective payment system and continued increases in the number of beneficiaries, expansion in both the number and type of participating providers and suppliers is expected to continue in the future. These factors will challenge Federal and State governments to become increasingly efficient and to ensure that providers and suppliers meet prescribed health and safety conditions. As part of this process, HCFA is committed to identifying providers and suppliers that are in noncompliance with health and safety conditions and to ensuring that corrections are made or, if necessary, terminating providers and suppliers from program participation. The program has been highly successful in eliminating facilities that fail to maintain key program requirements. For the three year period of FY 1985 through FY 1987, there were 3,104 voluntary terminations and 356 involuntary terminations. Voluntary terminations often include providers and suppliers that withdraw from participation rather than face expulsion. Strong enforcement will continue in outyears ensuring that substandard providers and suppliers are eliminated.

An annual agreement, budget and workplan are negotiated with each State survey agency (generally within the State Health Department) to perform onsite inspections in accordance with explicit Departmental regulations and HCFA instructions. HCFA-trained State specialists conduct onsite surveys of providers and suppliers to determine eligibility for Medicare and Medicaid program participation. If the surveyed provider or supplier is found to have deficiencies, a plan of correction is developed. The majority of providers and suppliers correct cited deficiencies, thus permitting continued program participation. Providers and suppliers that do not make necessary corrections within a prescribed amount of time are eliminated from the program.

Terminations

Facility Type	FY 1985			FY 1986			FY 1987		
	Voluntary[1]	Involuntary	Total	Voluntary[1]	Involuntary	Total	Voluntary[1]	Involuntary	Total
SNFs	103	27	130	110	54	164	110	60	170
ICFs	88	20	108	47	21	68	62	13	75
ICFs/MR	26	11	37	53	32	85	54	12	66
Hospitals	64	4	68	83	18	101	78	8	86
HHAs	312	3	315	391	12	403	337	6	343
OPTs	71	4	75	74	2	76	63	1	64
Labs	280	10	290	236	16	252	198	14	212
X-ray	18	0	18	25	1	26	13	1	14
ESRDs	12	0	12	12	0	12	13	1	14
RHCs	39	0	39	36	1	37	17	0	17
ASCs	10	0	10	20	1	21	16	1	17
Hospices	2	0	2	4	1	5	1	0	1
CORFs	11	0	11	9	0	9	6	1	7
Total	1,036	79	1,115	1,100	159	1,259	968	118	1,086

[1] Includes mergers, closures and voluntary withdrawals.

To ensure that States are conducting surveys in accordance with explicit criteria and instructions, a pool of approximately 110 highly skilled Federal surveyors perform random monitoring surveys. These surveyors are strategically distributed among HCFA's ten regional offices to ensure each office has a wide variety of surveyor disciplines available. Survey results are provided to States together with technical assistance to implement any recommended improvements to the survey process.

States submit detailed line item budgets each year for the estimated costs of performing Medicare survey activities. The budgets are negotiated by HCFA program and fiscal specialists ensuring each State is provided adequate staffing levels and associated salaries, fringe benefits, travel, training and indirect costs as mandated by each State's civil service requirements. The budget approval corresponds to an agreed to workload which ties to national survey coverage levels by provider and supplier type. Workload to be accomplished is then multiplied by prescribed time factors (developed via a HCFA task force which canvassed all States and HCFA Regional Offices for average inspection times for all facility types) to conduct survey activity and then multiplied again by each States' hourly rates for survey staff. This formula produces a unit cost budget utilized for final funding approval. HCFA requires States to submit quarterly cost and workload reports that are subject to Department of Health and Human Services audit by the Office of the Inspector General.

Relationship to Other Programs

The State certification program is an integral part of both the Medicare and Medicaid programs. Providers and suppliers are eligible to be paid for services to Medicare and Medicaid beneficiaries if they receive a certification that prescribed conditions and standards of health safety and quality have been met. Payment is only provided to those providers and suppliers that possess a certification. This process provides assurance to Medicare and Medicaid beneficiaries that products and services offered by certified providers and suppliers will be delivered at an acceptable level.

Rationale for the Budget Request

The FY 1990 request is $99,113,000, an increase of $33,254,000 above the level of support provided in FY 1989. This increase is attributable to:

- Cost of living increases by utilizing the State and Local Purchasing Deflator for all facility types which provides an inflation rate of 3.9 percent ($2,427,000).

- Program expansion to survey 881 Medicare providers and suppliers requesting program participation ($3,264,000).

  - Initial surveys are conducted almost immediately upon receipt of an application.

- Additional equipment needs to allow States to procure 1,600 laptop computers (one for every two surveyors) to facilitate more timely development and data entry of survey findings ($1,000,000). HCFA has successfully pilot tested the use of laptop computers by both Federal and State surveyors. This initiative has enhanced program operations by reducing data entry operator time and provides survey information more quickly for determining facility certification. All facility types will have software developed by FY 1990 to permit laptop usage. The actual cost to procure laptops is $4,000,000, however, HCFA projects $3,000,000 in productivity improvements will be realized.

- Increased coverage level for laboratories from 60 percent to 100 percent to enhance our oversight responsibilities ($3,793,000). HCFA needs additional resources and increased coverage to ensure these facilities meet program requirements. The current coverage level is not sufficient to ensure laboratories are complying with conditions for participation. Numerous problems have surfaced regarding incorrect laboratory findings which result in severe consequences (both psychological and physical) to beneficiaries. Our intensified efforts will allow more frequent inspections to ensure laboratories are providing correct diagnoses. The Senate Oversight and Investigations Committee and the House Energy and Commerce Committee held hearings with HCFA in 1988 which also surfaced the need for enhanced laboratory oversight. After FY 1990, HCFA will again evaluate its position on the required laboratory coverage levels. This will begin after HCFA has had the opportunity to analyze the scope of laboratory errors the expanded coverage may provide.

- State certification of high volume physician office laboratories ($5,000,000). The Omnibus Budget Reconciliation Act of 1987 modified section 1861(s) of the Social Security Act to provide certification of physician office laboratories that have a volume of clinical diagnostic laboratory tests exceeding 5,000 per year. HCFA will require each of these laboratories to go through an annual proficiency testing program from an approved organization. A contractor will compile information as a result of proficiency testing and provide the data to HCFA and State survey agencies responsible for ensuring compliance.

- Printing of the survey report forms used by the State surveyors ($300,000). This cost had previously been paid from the Medicare Contractors' Budget; however, HCFA believes it more feasible to charge these costs to the program which actually utilizes the survey forms.

- Implementation of an enhanced survey process and enforcement activity in HHAs and SNFs as a result of the Omnibus Budget Reconciliation Act of 1987 ($14,536,000).

- FY 1990 contract support of $6,558,000 to accomplish the activities outlined as follows ($2,934,000).

$300,000 (consultant) is required to develop and validate a basic surveyor training and test program. The OBRA of FY 1987 requires "The Secretary to provide for the comprehensive training of State and Federal surveyors in the conduct of standard and extended surveys..." In addition, the same provision continues with, "No individual shall serve as member of a survey team unless the individual has successfully completed a training and testing program in survey and certification techniques that has been approved by the Secretary." These requirements are effective on October 1, 1990. So that HCFA can meet this deadline, contract support will be needed on October 1, 1989. The substantive work on the contract will be to develop a test that will accurately measure the proficiency of a surveyor against on-the-job performance. The training program will be developed through other HCFA resources. HCFA does not have the staff with the necessary testing and validation skills required to fulfill this objective.

$200,000 (consultant) is required to develop an evaluation program for the nurse aide training and competency evaluation program. The OBRA of FY 1987 provided for the establishment of a nurse aide training and competency evaluation program. This would include requirements relating to the areas to be covered in the program such as minimum hours of initial and on-going training and retraining, qualification of instructors, and procedures for determining competency. Currently, a number of states require training of nurse aides, however, the scope and effectiveness of that training are not known.

$5,058,000 (non-consultant) is required for the oversight of two special conditions (staffing and medical records) in the 716 psychiatric hospitals that will be certified for participation in the Medicare/Medicaid programs. The average inspection cost is estimated to be $7,064. The contractor will be responsible for providing qualified mental health consultants, scheduling and conducting surveys, and providing expert technical assistance and consultation to providers, HCFA regional staff, and State agencies.

The number of participating psychiatric hospitals has been increasing substantially each year. This growth is attributed to increased consumer and corporate awareness of needed alcohol and drug treatment centers together with some States not requiring a certification of need prior to construction of a psychiatric hospital. In addition, hospitals have been converting previously designated acute care beds and utilizing them to establish psychiatric units within hospitals to address increased demand for psychiatric care. The level of funding provided in FY 1989 ($3.6m) will allow 9 months worth of contract work from January through September 1989. These resources will provide 12 months worth of contract work.

PARTICIPATING PSYCHIATRIC HOSPITALS

1985	1986	1987	1988	1989	1990
481	515	575	622	669	716

$100,000 (consultant) is required to improve surveyor capabilities in laboratories which will require HCFA to develop an enhanced laboratory training curriculum. Results of this study will provide HCFA with content, format and plans to assure that surveyors are aware of emerging laboratory technology and that they have an understanding of automated information systems in the laboratory together with procedures for assessing their accuracy and effectiveness. In addition, the curriculum will provide surveyors with an understanding of the issues involved in the choice of laboratory quality control systems. To devote as much expertise as possible to this effort, HCFA will coordinate its efforts with the Food and Drug Administration, Centers for Disease Control and the National Institutes of Health, together with utilizing expert consultants to assist in developing the required surveyor curriculum and training State surveyors.

$400,000 (consultant) is required to develop a surveyor training satellite network. The requirements of OBRA-1987 and the ongoing changes in survey methodology for Medicare/Medicaid providers and suppliers require that surveyors are trained prior to conducting surveys. In order to meet these requirements, surveyors must be fully trained as soon as possible after the issuance of final regulations and procedures. A contract to develop the satellite capability to provide surveyor training is needed. The contractor will research, develop, implement, and evaluate training sessions via satellite for their effectiveness in providing training to surveyors. This training would be transmitted to State capitals or other State locations across the nation. After implementation of this system, it is envisioned that surveyor travel and per diem costs would be reduced in the outyears and travel time would be redirected to survey activities. Approximately 1,400 surveyors attend HCFA sponsored training courses each year.

$500,000 (consultant) is required to develop and pilot test a series of training programs geared to improve the consistency in the application of Federal regulatory requirements. As a result of OBRA-1987, each State and the Secretary must implement a program to measure and reduce the inconsistencies in the application and interpretation of Federal regulations among surveyors. This contract will be designed to evaluate surveyor performance on-site after a pilot test of the course presentation. It will evaluate the behavior of surveyors when conducting surveys, and how that behavior relates to the techniques and practices taught in the course. HCFA proposes to issue a Basic Ordering Agreement to a single contractor that will be responsible for developing training and evaluation systems for various participating facility types.

The $92,555,000 requested for direct survey activity will support an acceptable level of survey coverage for each provider and supplier type, including initial surveys of new providers and suppliers requesting program participation and necessary complaint and/or followup visits for those currently certified. To accomplish this workload, States will require approximately 1,603 staff persons.

The requested level of funding provides survey coverage for approximately 94.0 percent of all providers and suppliers participating in the Medicare program. SNFs, HHAs, Hospices, and laboratories will be surveyed, on average, every 12 months to ensure they comply with program standards. All other facility types are on flexible survey cycles depending on their past compliance history.

Funds budgeted in FY 1990 will ensure that providers and suppliers having deficiencies on previous surveys will receive appropriate follow-up. Traditionally, the majority of providers and suppliers receive complaint investigations and/or onsite follow-up surveys to ensure cited deficiencies have been corrected. In addition to the onsite recertification surveys, studies indicate that each long-term care facility receives an average of 2.25 additional visits while approximately two-thirds of each surveyed non long-term care facility receives an additional visit each year. Approximately eight percent of the total staff and fiscal resources are devoted to this activity.

Inspection costs for Skilled Nursing Facilities that participate in both Medicare and Medicaid programs are shared equally between the two programs. In FY 1990, the Medicaid program will contribute approximately $37,272,000 to fund its share of the Medicaid costs for these dually participating providers.

Major Program Enhancement Initiatives

Develop Outcome-Oriented Surveys - HCFA will continue to improve upon outcome-oriented surveys for the long-term care facilities and develop methodologies for hospitals, home health agencies, hospices, ASCs, CORFs, and ESRD facilities. This will allow HCFA to move in the direction of linking for the first time, resource inputs to outputs and quality assurance activities to reimbursement in the area of long-term care.

The primary objectives in implementing this type of survey process are two-fold:

- To increase reliability by providing a survey process and reporting form that would ensure greater uniformity in terms of review approach, documentation, and certification decisions; and
- To increase the validity of the survey process by emphasizing surveyor review of outcomes and provision of care rather than paper and structural review, thereby allowing more time for direct resident observations and interviews.

Survey teams are standardized with respect to both numbers and disciplines. Residents selected for observation, interview, and assessment are representative of the facility population as a whole (random stratified sampling is employed).

A resident specific data base is established that complements facility deficiency data enabling a targeted approach to surveying. Additionally, a separate data set is utilized by surveyors to cite deficiencies when facilities exceed established tolerances (standards and norms).

Increase Surveyor Proficiency

The changes in survey methodology for Medicare/Medicaid providers and suppliers require highly skilled and trained surveyors. The skills and technical knowledge aspects required of surveyors demands the development of courses that are participatory by design and task-oriented in content. Approximately 32 courses will be conducted which will focus on the consistency in application and the accuracy in interpretation of regulations, policies, and procedures. These include the basic surveyor, laboratory and life safety code courses as well as speciality courses to focus on specific survey activities. Experts from the private sector are utilized to assist in developing and presenting courses designed to provide the surveyor first-hand application and interpretation of regulations in internship and laboratory settings.

Improve Survey Data

The survey and certification process and its inherent responsibilities requires a data management software system that reflects current technology, is responsive to our needs, is reliable and accurate, and has analytical capabilities. A software system meeting that description is one that is relationally interactive. A relationally interactive system has the capabilities of moving between different data systems, can be searched for individual items or sorted for selective variances and arrays, and allows performance of basic mathematical computations. A system of this magnitude can play a pivotal role in our plans to fully automate our monitoring and evaluation functions.

HCFA's specific plans include modifying the current data base to capture more resident specific information and less statistical and deficiency related information. HCFA will focus attention on outcomes of resident care rather than on provider and supplier compliance with the traditional structure and process.

To also enhance the current data process, HCFA has implemented a State agency direct data entry initiative which has substantially reduced data entry errors, eliminates unnecessary paper flow and provides more accurate and timely data. Computer screens are employed to generate certifications, deficiency data, and adverse action requirements. This has allowed HCFA to redirect staff resources and focus oversight activities on traditionally poor performers.

Implementation of OBRA 1987 - Survey Process

HCFA entered into a contract with the Institute of Medicine (IoM) to study the full range of nursing home regulatory and enforcement issues and to provide recommendations for changes in the system. The IoM formed a Committee on Nursing Home Regulations consisting of experts in gerontology, consumer advocates, State government officials, and nursing home industry representatives.

The major theme of the study focused on the overall quality of care and life in nursing homes. This was a distinct change from past studies of nursing homes which characteristically have focused on some aspects of poor care or services. Specific criticisms and recommendations were subsumed within the general context that nursing homes are "homes" as opposed to "institutions", and Federal regulations and enforcement should provide for assuring a broad range of appropriate care and services tailored to the specific needs of residents. The care and services must be directed to both the physical and mental well-being of residents across a broad spectrum of needs, including health care, psychological and social needs.

The IoM made extensive recommendations involving regulations and their enforcement, as well as non-HCFA programs such as the National Ombudsman program operated by the Administration on Aging, Office of Human Development Services. Major recommendations were made on the various aspects of the study many of which have been adopted by the Congress as reflected in the Omnibus Budget Reconciliation Act of 1987. As a result, strengthened survey and certification process and enforcement activity will focus on resident outcomes, quality of life and quality of care.

The majority of these provisions are effective October 1, 1990 and the survey process revisions are highlighted as follows:

- States are responsible for certifying compliance with a new set of nursing facility requirements for participation in Medicare/Medicaid. Major new requirements include annual resident assessments, 24-hour nursing coverage, nurses' aide training and pre-admission screening and review for mentally retarded and mentally ill individuals.
- States will conduct certification surveys using a new two-tier protocol (to be developed by the Secretary) consisting of a standard survey and an extended survey.
- States must conduct unannounced surveys at least every 15 months in each nursing home with an average of 12 months or less between standard surveys.
- The Secretary is responsible for certifying compliance for all State nursing facilities.
- The State will be responsible for certifying all private nursing home providers, even those participating in Medicare.
- The requirement that States conduct inspection of care review and physician certification in nursing homes is eliminated.

HCFA will devote the necessary staff time to ensure that these required enhancements to the survey process are implemented as mandated by statute.

Implementation of OBRA 1987 - Enforcement

HCFA is evaluating the effects of OBRA 1987 as they relate to enforcement activities and staff resources will be devoted to the development of the necessary regulations and policies needed to implement these requirements which are highlighted as follows.

HCFA will impose intermediate sanctions on home health agencies (HHAs) for deficiencies found which do not jeopardize the health and safety of the individuals receiving services of the agency. In the event the deficiencies pose an immediate threat to the health and safety of the individuals, immediate action will be taken by HCFA to remove the jeopardy and correct the deficiencies through the appointment of temporary management or to terminate the certification of the agency.

For clinical diagnostic laboratory tests, HCFA will develop and implement a range of intermediate sanctions and specific procedures on when and how each of the sanctions are to be applied.

For long term care facilities, if the deficiencies pose an immediate jeopardy to the health or safety of its patients, HCFA will take immediate action to remove the jeopardy and correct the deficiencies through appointment of temporary management or terminate the provider agreement. If the deficiencies do not immediately jeopardize the health or safety of its residents, HCFA will impose, in lieu of termination, specific remedies.

HCFA will devote the necessary staff time to ensure that these required enhancements to the enforcement process are implemented as mandated by statute.

Ensure Optimal State Survey Agency Performance

The Federal oversight role of State survey agency performance will be strenghthened through implementation of improved procedures to monitor 1864 Agreements to ensure that States perform survey and certification activities in an efficient and effective manner.

HCFA has developed criteria to redirect the monitoring and evaluation of 1864 Agreements to measure a State's performance of survey and certification activities against national standards of performance. Evaluation efforts will involve greater analysis of aggregated data of a State's system with less emphasis on review of individual provider and supplier certifications. The viability of the new evaluation process will require specific contract/agreement deliverables and related performance criteria that will be detailed in a new State Agency Evaluation Process.

The major Federal oversight activities of the regional office will involve the following:

- Monitoring the State survey agency through a State Agency Data System;
- Federal monitoring surveys;
- Annual negotiation and award of the 1864 Agreement;
- Preparation of annual State report; and

- Enhanced training and policy interpretation to ensure States are consistent in their survey process and enforcement activities.

Develop, Test and Evaluate a Resident Assessment Instrument for use by Nursing Facilities.

In OBRA 1987, Congress mandated that, effective October 1, 1990, all participating nursing facilities will be required to conduct a comprehensive assessment of each resident upon admission and at least annually thereafter. To ensure that such assessments are as standardized as possible, Congress has mandated that HCFA design and implement one or more instruments that can be used in conducting the resident assessments.

During FY 1988, HCFA will award a contract to:

(1) Develop, test and refine a resident assessment instrument; and

(2) Evaluate the implementation of the assessment instrument and prepare for the national collection and use of the assessment data.

The assessment instrument will produce comprehensive information on the functional capacities and care needs of each resident. It will provide facilities with all the information necessary to formulate an appropriate care plan for each resident, aimed at achieving the optimal level of physical, mental and psychosocial well-being.

Once the assessment instrument is in place, HCFA will develop and implement a national data collection system to permit access to and analysis of the assessment data. HCFA's long-range objective is the establishment of a comprehensive data base containing information about all Medicare/Medicaid residents in nursing homes.

ESRD

0212

FY 1990

END STAGE RENAL DISEASE NETWORK ORGANIZATIONS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

DECISION UNIT - ESRD NETWORK ORGANIZATIONS
(Budget Account - 75-0511-0-1-550)

Analysis of Resources
(Dollar in Thousands)

Total Program Level	FY 1988 Apportionment	FY 1989 Request	FY 1990 Request
Total Obligations	$6,613	$7,076	$7,571
Less Reduction to Composite Treatment Rate	-6,613	-7,076	-7,571
Total Budget Authority	$0	$0	$0

Total Program Level	FY 1991 Request	FY 1992 Request	FY 1993 Request	FY 1994 Request
Total Obligations	$8,101	$8,668	$9,275	$9,924

NOTE: FY 1990 and outyear estimates will be determined based on actual ESRD facility patient data as reported by the Medicare Contractors.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
END STAGE RENAL DISEASE NETWORK ORGANIZATIONS

Authorizing Legislation: Title XVIII, Social Security Act as amended, Section 1881.

Purpose and Method of Operation

Section 1881 of the Social Security Act, as amended by 1986 OBRA, authorized the Secretary to establish and support End Stage Renal Disease (ESRD) Network Organizations financed from the Medicare trust funds. The rapid expansion of ESRD facilities and the increase in the numbers of ESRD beneficiaries, together with the amount of the Federal investment in ESRD benefits, prompted the Congress to establish a mechanism to promote quality assurance and the effective utilization of resources in the delivery of services to ESRD patients. To accomplish these goals, ESRD Network Organizations are required to perform the following statutorily mandated activities:

- Develop criteria and standards for the review of patient and medical care practices.
- Conduct onsite facility reviews, as necessary, to assure proper medical care rendered and to report to the Secretary those facilities that are not providing proper medical care.
- Evaluate facility procedures for placing patients in appropriate treatment modalities.
- Encourage the participation of patients and facilities in vocational rehabilitation and develop criteria and standards relating to such encouragement.
- Implement procedures to evaluate and resolve patient grievances.
- Identify and report to the Secretary facilities that do not comply with network goals and objectives.
- Collect, verify and analyze data submitted by ESRD facilities.
- Support a National ESRD data registry.

These functions and activities are further delineated in CFR Title 42, Part 405, Subpart U and other administrative guidelines.

Each Network Organization is required to establish a network council of renal dialysis and transplant facilities located in each designated area together with a medical review board. The medical review board includes physicians, nurses, and social workers engaged in providing treatment to patients with renal disease and includes at least one patient representative. It also encourages facility cooperation with network organizations. Each network organization is funded on a competitive contract basis and requires a full time professional staff of 4-5 people to administer the annual award.

During CY 1988, HCFA will reduce the number of network areas from 32 to 18. The current configuration of 32 councils resulted in a fragmented and inconsistent approach to quality assurance issues. Each council developed its own specific set of objectives and data bases that were not compatible across network boundaries. The 32 network area configuration made it difficult for HCFA to effectively monitor network performance and conduct meaningful demographic and statistical analyses on a national scale. Therefore, a lesser number will be implemented to more effectively address program goals and objectives.

Rationale for the Funding Estimate

The Omnibus Budget Reconciliation Act of 1986 removes annual funding requests for ESRD Network Organizations from the appropriations process. Effective January 1, 1987, Subsection (b)(7) of Section 1881 of the Social Security Act was amended by adding at the end of the following new sentence: "The Secretary shall reduce the amount of each composite rate payments under this paragraph for each treatment by 50 cents (subject to such adjustments as may be required to reflect modes of dialysis other than hemodialysis) and provide for payment of such amount to the network administrative organization (designated under Subsection (c)(1)(A) for the network area in which the treatment is provided) for its necessary and proper administrative costs incurred in carrying out its responsibilities under Subsection (c)(2)."

Based on the most current patient census data available (CY 1986), there are approximately 90,500 ESRD patients. Of these, approximately 84,800 are Medicare beneficiaries under the composite treatment rate. Each patient, on average, received 3.0 treatments per week which computes to 13.2m treatments per annum. At 50 cents per treatment, by CY 1990 the ESRD Network Organization program would receive $7.5M from funds within the Medicare Supplementary Insurance Trust Funds which otherwise would have been provided to ESRD facilities. This assumes a projected patient growth of approximately 7 percent which the program has been experiencing over the past several years.

HCFA has issued instructions to its Medicare Contractors outlining the recoupment procedures to be utilized regarding the 50 cent reduction. Data with regard to actual monetary reductions by facility and network area will be transmitted to HCFA via billing reports. This data will serve as the most accurate source of information for estimating outyear requirements beginning with the CY 1989 contract cycle.

ADMINISTRATIVE COSTS

FY 1990

ADMINISTRATIVE COSTS

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
DECISION UNIT - ADMINISTRATIVE COSTS
(Budget Account 75-0511-010-550)

Analysis of Resources
(Dollars in Thousands)

Program Level	FY 1988	Revised FY 1989	FY 1990
Total Program Level	$253,827	$283,108 2/	$307,083 2/
Total Obligations (non-add)	$252,789 1/	$283,108 2/	$307,083 2/
Less Trust Fund Transfers	$171,570	$201,358	$225,561
Less User Fee	$1,557	$283	$283
Budget Authority	$80,700	$81,467	$81,239
FTE Employment (Work Years)	3,829 3/	4,171 4/	4,292 4/

Program Level	FY 1991	FY 1992	FY 1993	FY 1994
Total Program Level	$310,870 2/	$314,189 2/	$316,992 2/	$319,859 2/
Total Obligations (non-add)	$310,870 2/	$314,189 2/	$316,992 2/	$319,859 2/
Less Trust Fund Transfers	$228,343	$230,781	$232,839	$234,945
Less User Fee	$283	$283	$283	$283
Budget Authority	$82,244	$83,125	$83,870	$84,631
FTE Employment (Work Years)	4,292 4/	4,292 4/	4,292 4/	4,292 4/

1/ Reflects the travel reduction of $1,038,000 as required in the FY 1988 Continuing Resolution.

2/ Excludes funds for Catastrophic Health Insurance.

3/ Reflects anticipated consumption. The FY 1988 ceiling is 3,860; however, the level of funding and other competing needs will limit FTE consumption to 3,829.

4/ Includes 125 FTEs for Catastrophic Health Insurance. Funds for these FTEs are not displayed on this chart but shown in the Catastrophic Health Insurance Section.

FY 1990 Budget Request
Administrative Costs
Object Classifications

(Dollars in Thousands)

Object Class	FY 1988	Revised FY 1989	FY 1990	Change
Total Personnel Compensation	$148,067	$161,020	$167,428	+ $6,408
Personnel Benefits	$21,980	$23,938	$24,895	+ $957
Travel	$4,710	$6,048	$6,266	+ $218
Transportation of Things	$430	$393	$407	+ $14
Rents, Communications and Utilities				
Rental Payments to GSA	$13,598	$14,863	$15,309	+ $446
Rental Payments to Other	$578	$637	$725	+ $83
Communications Utilities and misc. charges	$6,806	$7,142	$7,667	+ $525
Printing	$2,539	$2,512	$2,602	+ $90
Other Services (Effectiveness)	$44,518	$47,816	$71,776 (25,000)	+ $23,960
Supplies	$1,694	$2,102	$2,358	+ $256
Equipment	$7,869	$16,637	$7,650	- ($8,987)
Total Obligations	$252,789	$283,108 1/	$307,083 1/	+ $23,975
FTEs	3,829 2/	4,171 3/	4,292 3/	+ 121
User Fees	$1,557	$283	$283	--

1/ Excludes funds for Catastrophic Health Insurance.

2/ Reflects anticipated consumption. The FY 1988 FTE ceiling is 3,860; however, the level of funding and other competing needs will limit FTE consumption to 3,829.

3/ Includes 125 FTEs for Catastrophic Health Insurance. Funds for these FTEs are not displayed on this chart but are shown in the Catastrophic Health Insurance section.

FY 1990 Budget Request
Administrative Costs
Summary of Changes

(Dollars in Thousands)

FY 1989 President's Request	$271,100
Transfer of the HI/SMI Automated Data Processing Workload from the Social Security Administration	$12,008

Revised FY 1989 Current Request	$283,108
Increases:	
Built-in Increases:	
Additional FTEs (121) 1/	$5,479
Employee Within Grades	$943
Annualization of FY 1989 Pay Raise	$943
Space Rental	$446
Postage	$288
Telecommunications	$417
Inflation	$1,692
Program Increases:	
Effectiveness Initiative	$25,000
Working Capital	$0
Automated Data Processing (HDC)	$937

Subtotal	$36,145
Decreases:	
Built-in Decreases:	

Program Decreases:	
PRISM	($1,890)
Transfer HI/SMI ADP workload	($10,280)

Subtotal	($12,170)
Total FY 1990 Request	$307,083 2/

1/ Excludes FTEs for Catastrophic Health Insurance.

2/ Excludes funds for Catastrophic Health Insurance.

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HEALTH CARE FINANCING ADMINISTRATION

ADMINISTRATIVE COSTS

Authorizing Legislation: Reorganization Act of 1953

Purpose and Method of Operations

The Administrative Costs budget activity provides the necessary operating funds to enable the Health Care Financing Administration (HCFA) to carry out its program responsibilities. These responsibilities include managing the Medicare and Medicaid Programs, coordinating Federal survey and certification efforts, and directing a variety of activities to assure quality health care. In FY 1990, the Medicare and Medicaid programs will account for over $146 billion of the Federal budget outlays and will serve over 56 million Americans.

HCFA staff are continually working toward improving the delivery of health care services through the Agency's programs. In FY 1990, HCFA staff will continue ongoing efforts and undertake additional initiatives to: (1) encourage development of Health Maintenance Organizations as a cost-effective alternative to the traditional form of fee-for-service health care; (2) promote competition in the health care industry; (3) implement Medicare program modifications designed to improve the quality of care; (4) reduce Medicare and Medicaid program costs through increased fiscal reviews and third party oversight activities; (5) reduce unnecessary regulatory and administrative burdens and (6) continue the development of a process for determining effective treatments for improving the health status of beneficiaries.

Because the Administrative Costs budget activity provides for the operating expenses in support of the administration of the Medicare and Medicaid programs, the funds for this activity are provided through the appropriation of general Treasury funds and transfers from the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds. In addition, user fees collected from Health Maintenance Organizations (HMO) seeking Federal qualification will be credited to this appropriation.

Rationale for Revised FY 1989 Budget Request

The FY 1989 request for Administrative Costs is revised to include the transfer of $12,008,000 from the Social Security Administration (SSA) to HCFA for the migration of the Hospital Insurance (HI) and the Supplementary Medical Insurance (SMI) automated data processing workload. In addition, this revised request reflects the absorption of $2,707,000 for the FY 1989 anticipated pay raise cost and the reduction of monies collected from Health Maintenance Organizations (HMOs) seeking federal qualification from $1,557,000 to $283,000.

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Transfer of the Hospital Insurance/Supplemental Medical Insurance System

Currently, HCFA relies on two sites for automated data processing, SSA's National Computer Center (NCC) and the HCFA Data Center (HDC). SSA was the primary source of ADP support for all Medicare central office operations. Recently, more of HCFA's support needs are coinciding with SSA's own peak workload periods resulting in HCFA's inability to have its requirements met. To assure responsiveness to mission needs, HCFA has gradually consolidated ADP support for Medicare/Medicaid statistical systems, program management systems and administrative systems at the HDC. However, at this point, HCFA remains operationally dependent on SSA for Medicare's query response and beneficiary master file processing.

As HCFA implements the Project to Redesign Information Systems Management (PRISM) and responds to new administrative and legislative requirements, a critical factor for success will be its ability to control all of its ADP resources. In FY 1989, HCFA plans to expand the HDC to support the HI/SMI System which currently operates at SSA's NCC. The FY 1989 revised budget request reflects the transfer of $12,008,000 from SSA to HCFA for this system.

Of the $12,008,000 requested to be transferred, $10,280,000 is required for one time investment in hardware and software. The remaining $1,728,000 is for annual continuation costs.

The actual transfer of the workload could be accomplished gradually between 1989 and the end of FY 1990, and could be coordinated with related efforts to implement the Common Working File and, upon enactment, provisions of the Catastrophic Health Insurance legislation.

Rationale for FY 1990 Budget Request

The FY 1990 budget request for Administrative Costs is $307,083,000. This represents an 8 percent increase over the revised FY 1989 request and includes only those costs that are necessary to enable HCFA to effectively and efficiently carry its mission. The $307,083,000 that is being requested is required for items that support HCFA's workforce (personnel compensation, rents, postage, telephone costs, transportation, travel, supplies, and training), support HCFA's efforts to upgrade and maintain its management information system, pertain to contracts that are essential for program reviews and analyses and provide funding for the effectiveness initiative.

In building the FY 1990 budget, all nonrecurring costs were eliminated. Accordingly, the FY 1990 budget has been reduced by $10,280,000 and $1,890,000 for one time costs associated with the transfer of the HI/SMI ADP workload from SSA to HCFA and the PRISM effort. Major increases to the revised FY 1989 request

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include $1,585,000 in salary costs for 35 additional full-time equivalents (FTEs), $3,894,000 for 86 FTEs associated with the Administrative Law Judge (ALJ) appeal process, $1,886,000 for employee within grades and annualization of the FY 1989 proposed pay raise costs, $25,000,000 for the effectiveness initiative, $2,843,000 for General Services Administration (GSA), postal and inflationary increases, and $937,000 for maintenance, supplies, and telecommunication costs resulting from additional ADP equipment scheduled to be used throughout the Agency in FY 1990.

The FY 1990 budget request is based on funding an FTE level of 4,167. The additional 125 FTEs which are included in the ceiling request and discussed in the section "Rationale for FTE Request" are to be funded as part of the Catastrophic Health Insurance program request. The request includes an additional 35 FTEs for new and increased workload requirements above the revised FY 1989 maintenance level. The request also includes an additional 86 FTEs for the ALJ appeal process. This request provides a total of 240 FTEs for the ALJ activity. Although committed to holding down its staffing levels, in order to meet the demands of increasing workloads and new functions HCFA must be able to develop its analytical and management capacity. The FTE request is explained in more detail in the "Rationale for FTE Request" section of this narrative.

The FY 1990 budget request also provides $13,050,000 to continue HCFA's plan to upgrade its information management system. This effort, which is referred to as the Project to Redesign Information Systems Management (PRISM), is essential if HCFA is to maintain a viable management information system that can support the need for comprehensive, accurate, and timely data for policy development and program management initiatives. The FY 1990 request is consistent with the approved Departmental plan. The PRISM request is explained in more detail in the "Rationale for PRISM Funding Request" section of this narrative.

For the most part, all object classes were maintained at their revised FY 1989 levels adjusted only for inflation.

Effectiveness Initiative

The FY 1990 Administrative Costs budget request includes $25,000,000 in support of the effectiveness initiative. The goal of the effectiveness initiative is to provide a more rational, scientifically and empirically-based process for determining effective treatments for improving the health status of beneficiaries. In this first phase of a multi-year plan, the emphasis of the Administrative Costs request is to update current data systems to enhance HCFA's ability to monitor quality and effectiveness of care. In addition, the budget request includes funds for the collection, analysis and dissemination of information on effective treatment modalities in order to improve the quality of care rendered to beneficiaries.

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Personnel Compensation and Benefits

The FY 1990 budget request includes $192,323,000 to fund 4,167 FTEs. This amount reflects an increase of $7,365,000 from the revised FY 1989 request as shown below:

- an increase of $1,585,000 for 35 additional FTEs.
- an increase of $3,894,000 for 86 additional FTEs for ALJ activities.
- an increase of $943,000 for employee within grades.
- an increase of $943,000 for the annualization of the FY 1989 pay raise costs.

The 4,167 FTEs include 80 FTEs that are currently allocated to the Social Security Administration for the Medicare Part A hearings and appeals activities.

Travel

The FY 1990 budget request includes $6,266,000 for travel. This amount reflects an increase from the revised FY 1989 budget request of $218,000 for inflation. This increase is required to offset anticipated increases in airfare, per diem and other related travel costs.

Transportation of Things

The FY 1990 budget request includes $407,000 for transportation of things. This amount reflects an increase from the revised FY 1989 budget request of $14,000 for inflation.

Rents, Communications and Utilities

The FY 1990 budget request includes $23,701,000 to fund space rental, communication and utility costs. This is an $1,059,000 increase over the revised FY 1989 request as shown below:

- an increase of $20,000 for inflation.
- an increase of $446,000 for space rental costs.
- an increase of $88,000 for the lease of software packages.
- an increase of $417,000 for voice communication costs associated with increasing FTS costs.
- an increase of $288,000 for an anticipated postal rate increase.
- a decrease of $200,000 in telecommunication costs.

The largest component of rent, communications and utilities costs is space rental. These costs are paid directly to the GSA. Space rental rates are established by GSA and affect all the buildings occupied by HCFA staff in Washington, D.C., Woodlawn, Maryland and the 10 regional offices. The Agency's space rental costs reflect a net increase of $446,000 over the revised FY 1989 budget request. This increase represents an anticipated 3 percent GSA rate increase. The FY 1990 request also reflects the Department's space consolidation policy that requires HCFA maintain a target of 135 square feet of office space for each employee by FY 1990.

The request includes a net increase of $217,000 for communication costs. This increase results from an anticipated 10 percent increase in Federal Telecommunication System (FTS) costs and for increases to telephone contracts for line usage within HCFA's 10 regional offices. This increase, in part, is offset from a reduction in data communication costs.

The request includes additional funds for an anticipated 10 percent postal rate increase.

Printing

The FY 1990 budget request includes $2,602,000 for printing. This amount reflects an increase from the revised FY 1989 budget request of $90,000 for inflation.

Other Services

The FY 1990 budget request includes $71,776,000 for Other Services. This is an increase of $23,960,000 from the revised FY 1989 request. The increase results from the following items:

- an increase of $675,000 for inflation.
- an increase of $25,000,000 for the effectiveness initiative.
- an increase of $876,000 for additional costs associated with HCFA's ongoing ADP operations.
- a decrease of $955,000 for one time cost associated with the transfer of the HI/SMI ADP workload from SSA to HCFA.
- a decrease of $1,636,000 for contractual services and training activities related to the PRISM initiative.

The largest component of Other Services pertains to contracts that enhance HCFA's ability to effectively and efficiently carry out its program objectives. These contracts fund such ongoing activities as: (1) the validation of medical determinations by

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Peer Review Organizations; (2) the technical assessment of Health Maintenance Organizations for Federal qualification and Competitive Medical Plans for Federal eligibility; (3) beneficiary information programs; (4) Medicare premium billing and collection activities; (5) Medicaid financial audits and MEQC re-reviews; and (6) administrative support services such as the warehouse, the mailroom, and the Baltimore/D.C. shuttle. The FY 1990 budget request for operating contracts was maintained at revised FY 1989 levels adjusted for inflation. However, in accordance with Departmental guidance, this budget request does not include any increase for the Office of the Secretary's Working Capital Fund.

In FY 1989, HCFA plans to purchase more than $16.6 million of ADP equipment. Additional costs will be incurred to properly maintain this equipment. Without adequate ongoing maintenance, the PRISM initiative will not yield all of the results anticipated. Accordingly, HCFA expects to spend an additional $861,000 for maintenance and machine repair costs in FY 1990. An additional $15,000 is requested to fund additional ADP training requirements for the HCFA staff.

Supplies and Materials

The FY 1990 budget request includes $2,358,000 for supplies and materials. This amount reflects an increase of $256,000 over the revised FY 1989 request. This increase includes $76,000 for inflation and $220,000 for additional automated data processing supplies such as disks, ribbons, cables, and manuals. These costs are necessary to support the increased number of minicomputers, electronic word processors, and other ADP equipment that will be used by the Agency in FY 1990. These costs are offset, in part, by a decrease of $40,000 for one time purchases required as a result of the transfer of the HI/SMI ADP workload from SSA to HCFA.

Equipment

The FY 1990 budget request includes $7,650,000 for equipment. This amount reflects a decrease of $8,987,000 from the revised FY 1989 request as shown below:

- an increase of $599,000 for inflation.
- a decrease of $47,000 in the purchase of data processing equipment.
- a decrease of $254,000 in the purchase of PRISM related equipment.
- a decrease of $9,285,000 for the one time computer hardware purchases associated with the transfer of the HI/SMI ADP workload from SSA to HCFA.

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As part of the Agency's effort to modernize and redesign its information system, HCFA will purchase $5,990,000 of ADP equipment in FY 1990. To support the PRISM end user computing initiative, HCFA plans to purchase additional minicomputers and personal computers. In addition to these major acquisitions, HCFA plans to purchase peripheral ADP equipment, such as disk storage and controllers, high speed communication links, and security devices. These equipment purchases are essential to support the PRISM effort. PRISM is explained in more detail in the "Rationale for PRISM Funding Request" section of this narrative.

User Fee Collections

The costs of salaries and expenses to fund the administrative cost activities will be derived, in part, from the assessment of user fees under the User Charge Statute (31 USC 9701). This statute permits such assessments when it is determined that a private benefit results from the service provided. User fees will be collected from HMO's seeking Federal qualification. Appropriation language is requested to provide full budget authority upfront with a subsequent offset to the appropriation by the amount of user fees eventually collected.

The funds derived from user fees will provide for the continuing effort to promote the HMO concept and to encourage HMOs to sign risk contracts to serve Medicare beneficiaries. Approximately 20 organizations are expected to apply for Federal qualification review and service area expansions during FY 1990.

Rationale for Full-Time Equivalent (FTE) Employment Request

HCFA is requesting an FTE ceiling of 4,292 in FY 1990. This request will provide 3,927 FTEs for ongoing operations, 125 FTEs to implement Catastrophic Health Insurance, and 240 FTEs for Administrative Law Judges.

HCFA is committed to holding down Federal employment. However, demands on the Agency continue to increase as the Congress enacts new legislation and the Administration continues its efforts to reduce the growth of health care costs, manage HCFA's fiscal agents more effectively, and avoid waste and inefficiency in the Medicare and Medicaid Programs.

HCFA has the primary responsibility or major support role in most of the Secretary's policy priorities -- alternative payment systems, physician payment reform, quality assurance, and competition. Moreover, demands on HCFA have increased substantially as a result of new legislative requirements -- most notably the implementation of the Catastrophic Health Insurance program. In order to respond to the demands being placed upon it and effectively carry out its program responsibilities, HCFA must be provided the necessary staffing resources.

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Ongoing Operations

HCFA is requesting 3,927 FTEs for ongoing operations in FY 1990. This is an increase of 35 FTEs over the current FY 1989 FTE base of 3,892 and 155 FTEs over the FY 1990 FTE base target of 3,772 for ongoing operations.

HCFA's FTE ceiling was reduced every year between 1980 and 1987. The loss of irreplaceable skills and institutional memory has been significant. Some kinds of expertise, i.e. program and management analysts can be developed by reallocating personnel from low priority to high priority functions but this requires considerable training and a lengthy lead time. Other kinds of expertise, i.e. actuaries, economists, policy analysts, and specialists in the health care field can only be obtained outside the Agency through a lengthy recruitment process. HCFA's FTE reductions, however, have limited its ability to hire from outside the Agency, severely affecting its ability to manage the many changes currently taking place in the Medicare and Medicaid programs.

In the past HCFA addressed its significant FTE reductions by cutting back in lower priority areas such as overhead and administrative functions. For example between FY 1984 and FY 1987, there was a 17% decrease in FTEs associated with management and data, and a 34% decrease in FTEs in program evaluation and technical assistance. However these lower priority activities, as well as HCFA in general, have now been reduced to a minimum operational FTE level.

HCFA has reached the breakeven point where it can no longer absorb FTE reductions or increased workload demands and still effectively do its job. This is especially alarming considering the current Administration and congressional emphasis on HCFA's programs. Without the requested increase in ceiling, there will be a negative impact on HCFA's ability to fulfill its current program objectives.

As mentioned, the program objectives which drive the activity of HCFA have been increasing as a result of congressional action. Recent reconciliation bills have included numerous provisions greatly increasing HCFA's workloads. Examples of the workload impact of those provisions, as well as other increased requirements, are:

- enhanced oversight of State survey agency performance requiring over 450 additional surveys and increased oversight to curb dumping;
- development, implementation, and maintenance of a new medical coding system serving as the basis for directing cases to DRGs in the prospective payment system (PPS);

- physician payment reform;
- development and implementation of a severity index to adjust PPS payments based on degree of patient's illness;
- development of new coverage policy and conditions of participation for long term care;
- review and analysis of home health care coverage policy;
- development of an electronic hospital cost reporting system;
- review of State plan modifications to include Medicaid disproportionate share hospital payments;
- review of heart transplant facility standards;
- resolution of issues dealing with AIDS (with Medicaid as the largest single payor of health care for persons with AIDS);
- expansion of Medicare secondary payor provisions to other groups of eligible persons and other types of payment situations; and
- implementation of the effectiveness of care research initiative.

As a result of the added functions and increased workload demands, HCFA is requesting a base staffing level of 3,927 FTEs for FY 1990. This will provide HCFA with the necessary staffing resources to carry out its significant program agenda.

Additional FTE Requirements

HCFA is requesting 125 FTEs in FY 1989 and FY 1990 to implement catastrophic health insurance and perform necessary ongoing activities such as designing and maintaining the necessary data systems, providing beneficiary information, and calculating the annual premium. These additional FTEs are necessary to implement and manage catastrophic health insurance in an orderly and efficient manner.

HCFA's original request for 50 FTEs was based on the initial proposed catastrophic legislation. However, subsequent additions to the proposed legislation have added prescription drug coverage and further additional labor intensive activities. As indicated in the provisions of the Conference Committee report, the catastrophic legislation will add significant data system and reporting requirements as well as the intensive effort of implementing the program in a timely fashion. To meet these new demands, HCFA is requesting an additional 75 FTEs. Thus, the total request is for 125 FTEs to implement the Catastrophic Health Insurance Program in FY 1989 and FY 1990.

HCFA is requesting 240 FTEs in FY 1990 for Medicare hearings and appeals function. Section 9341 of OBRA requires an administrative appeals process for Medicare Part B claims similar to the one currently available for Part A claims. The Management Council's decision to consolidate the appeal process for both Part A and Part B claims within HCFA will require 240 FTEs based on current workload projections.

Rationale for PRISM Funding Request

Background

To effect improvements in the Agency's data processing environment, HCFA has embarked on PRISM. PRISM was initiated in 1982 when it became obvious that HCFA's ADP environment was inadequate to handle the Agency's growing need for information, and that failure to modernize its information systems would result in severe deterioration of systems support. The system redesign process began with HCFA Mission Needs Study which documented the Agency's information requirements. Subsequently, a systems design concept and an implementation plan were developed with the assistance of the MITRE Corporation. In 1985, the PRISM implementation plan was presented to and approved by the Department.

The PRISM initiative encompasses all of HCFA's internal systems, including the interfaces with HCFA's fiscal agents. The Central Office systems for claims processing, program management, programmatic decision support, and administrative support will be modernized to improve the quality and timeliness technology. In addition, the interfaces with the State Agencies, Fiscal Intermediaries, Carriers and Peer Review Organizations will be improved to facilitate exchange of data via automated methods.

In addition to the improved access to program data, office automation will extend to both Central and Regional Office staff the word processing, scheduling and data manipulation capabilities of the electronic work station.

Rationale for FY 1990 Funding Request

HCFA must get a state-of-the-art data system in place as soon as possible. PRISM will provide HCFA and Administration policy officials with an information system that supports policy development and program management needs. Over the next few years, the Congress and the Administration will be moving forward with significant health care policy changes. PRISM must be in place to support such efforts.

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FY 1990 Funding Request

The FY 1990 budget request for PRISM is $13,050,000. Although FY 1990 was to be the final year of the PRISM effort, an extension of the overall period of the software development activities was granted by the Department. Without additional funding, the extension allows software development activities to continue through FY 1991. The FY 1990 funding request is categorized as follows:

	FY 1990 Request
Systems Integration	$ 375,000
Software Development	4,375,000
Maintenance/Training	705,000
Hardware and Software (HDC)	2,855,000
End-User Computing	4,005,000
Data Administration	735,000
	$13,050,000

1) Systems Integration

In FY 1990, HCFA will review the final product to assure that it is consistent with the selected design concept and provides the type of systems support required by the Agency.

2) Software Development

Design

The purpose of the major software redesign contract is to provide the analysis, design, and specification development of comprehensive applications systems software that will support HCFA's programmatic data processing requirements into the turn of the century. During FY 1990, the design contractor will be completing the detailed system and providing a smooth transition between the analysis and subsystem specifications, validating portions of the redesign systems, and the coding phases.

Development

The actual software development will begin in late FY 1988 and continue through FY 1991. HCFA's procurement strategy for this effort is to acquire one or more performance-to-completion, cost-plus-fixed fee contracts. This effort will include coding, testing conversion, and implementation of comprehensive redesigned applications systems software.

Independent Verification and Validation (IV/V)

In addition to the high-level IV/V support which the MITRE Corporation will provide, HCFA is acquiring the services of

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a contractor for detailed review of application software design, data base design , and software code that the redesign contractors are developing.

3) **Maintenance/Training**

Since HCFA's legislative and regulatory agenda historically has been quite dynamic, HCFA has allocated a portion of the PRISM budget to ensure interim requirements are adequately addressed during the redesign period. In addition, contractor support is needed to maintain the current systems while HCFA staff is involved in the Redesign effort. A full-scale comprehensive training program to upgrade the skills of HCFA staff will continue in FY 1990.

4) **Hardware and Software**

In FY 1990, HCFA plans to make a second payment on the upgrade to the IBM 3090 processor and the phased acquisition of systems software and peripheral devices for the HCFA Data Center. The acquisition program will concentrate on a mix of storage devices to meet the range of requirements by the redesigned systems, and several data communications devices to provide improved capabilities and security.

5) **End-User Computing**

Under this initiative, HCFA will provide managers direct access to information for decision-making, provide program analysts with the tools to utilize subject matter data bases, and provide clerical support staff with integrated office automation capability.

6) **Data Administration**

The primary goal of this effort is to assure HCFA has the information to support critical program policy, program development, and management decision requirements. By implementing a Data Base Management System (DBMS) approach to organizing and storing data in HCFA, PRISM will provide a data framework which will give end-users the information they need to support these requirements in an accurate, timely, and efficient manner. Data administration staff will work with the Redesign contractors to assure that the data/information needs are properly incorporated and to direct the implementation of the selected Data Dictionary System.

It is very important to note that, even though these efforts can be described separately, they are very interdependent. For instance, it would be of little benefit to continue to build office automation capability throughout the Agency if the project to redesign the data files and related software were not pursued.

PRISM has already shown that the major impact of office automation is realized when users have direct and immediate access to data files. Without this aspect of office automation, the capability is reduced to such uses as local spread sheet applications and electronic mail. While these are useful, they are not as beneficial as the ability to access data files directly.

This principle applies throughout PRISM. For instance, increased hardware acquisitions are necessary if additional microcomputers are purchased and data administration becomes increasingly important as PRISM builds more user-oriented data bases.

Program Achievements and Benefits

HCFA expects to gain significant qualitative and quantitative benefits from PRISM. These benefits arise from improvements in accessibility and quality of data necessary to make major programmatic decisions; level of service to providers, contractors, and the public; and ease of maintenance and modification of ADP applications. Increased productivity will give HCFA the ability to explore new legislative or operational initiatives and recommend cost effective changes.

FUNCTIONAL HIGHLIGHTS AND ACCOMPLISHMENTS

1. Program Administration

This function, much of which is mandated by law, encompasses an assortment of responsibilities involved in the administration of the Medicare program and oversight of the Medicaid program. Specific activities include:

Medicare

- Development, negotiation, maintenance and modification of primary contracts with intermediaries and carriers, including those awarded on an experimental basis.
- Monitoring and evaluation of Medicare contractors' performance in carrying out statutory and contractual responsibilities.
- Monitoring and evaluation of Competitive Medical Plans to assure they meet financial and organizational regulatory requirements and are complying with Medicare contract requirements.
- Monitoring HMOs with Federal loans authorized under Title XIII of the Public Health Service Act to assure timely repayment of loans and compliance with loan agreements.
- Development and maintenance of a comprehensive program to contract with and make payments to a variety of prepaid health plans including Health Maintenance Organizations and Competitive Medical Plans (HMO/CMP) for provision of services.
- Review of provider requests for exceptions to reimbursement limits (e.g., TEFRA rate of increase ceilings, section 223 cost limits, End Stage Renal Disease (ESRD) composite rates).
- Hearings of the Provider Reimbursement Review Board (PRRB) to resolve disputes on cost reimbursement and prospective payment submitted by Medicare providers under section 1878 of the Social Security Act. This is the initial step in the judicial review process.
- Review of PRRB decisions by the Attorney Advisor and affected HCFA components to: (1) ensure compliance with all applicable laws, regulations and policy issues; and (2) recommend decisions under section 1878(f) of the Social Security Act ("own motion" review), as amended. Review of Hearing Officers' decisions concerning reconsideration of Medicaid State Plan Amendments.

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- Administration of subcontracting initiatives with small and disadvantaged businesses to enhance competition in subcontracting.

- Compute and update urban and rural average standardized amounts for approximately 6,000 hospitals to pay for inpatient operating costs under the prospective payment system pursuant to section 1886(d)(3) of the Social Security Act and update TEFRA ceilings per section 1886(d)(3)(B) for 1,700 hospitals and hospital units and publish such rates by September 1 of each preceding Federal fiscal year.

- Preparation of proposed and final diagnosis related group (DRG) classification notices annually.

- Perform consultation and liaison with newly established Office of Rural Health.

- Develop and implement HCFA central office and contractor systems and procedures to implement legislative initiatives and changes in regulations.

- Monitor intermediary and carrier activity to identify and act upon all potential conflict of interest situations, including provider ownership.

Medicaid

- Review and approval of State Medicaid Plans to ensure compliance with Federal laws and statutes.

- Conduct ongoing review of State Medicaid plans to identify deficiencies and appropriate corrective actions to be taken.

- Review of requests for State Medicaid Plan amendments/preprints and waivers of certain program requirements in order to help States gain greater flexibility in administering the Medicaid program.

Major Highlights/Significant Accomplishments

- HCFA processed 96 hospital exception requests, 224 ESRD exception requests, 122 Home Health Agency (HHA) exception requests, 85 Skilled Nursing Facility (SNF) exception requests, and conducted 30 hearings.

- HCFA reviewed 140 PRRB decisions (including jurisdictional decisions), prepared 133 court actions and reviewed 14 State Plan Amendment decision/withdrawals.

- HCFA processed 548 Medicaid plan amendment requests and 574 waiver and waiver modification requests.

- HCFA issued instructions and payment rates to implement the Access to Skilled Nursing Facilities Provision of the Consolidated Omnibus Budget Reconciliation Act of 1985(COBRA). The payment rates, the methodology for computing the rates and the requirements a skilled nursing facility must meet to be eligible to elect payment under this prospective payment system were issued for cost reporting periods beginning on and after October 1, 1986. An update of these rates was published in September 1987.

- The Medicare Benefit Notice workload has been completely transferred from SSA to the intermediaries. This change places notices in the hands of the beneficiaries several weeks sooner than under the old system.

- To increase efficiency, HCFA in FY 1987 transferred approximately 300 free-standing home health agencies to 10 regional intermediaries.

- In FY 1987, HCFA saved over $1 billion through its Medicare Secondary Payer (MSP) program by recovering improper payments from primary payers or avoiding payments that should have been made by primary payers. The ratio of savings to administrative costs is in excess of 20:1. Similar savings are expected for FY 1988.

- In FY 1987, HCFA expanded the MSP program to include certain disabled beneficiaries.

- HCFA collected, analyzed and prepared detailed descriptions of deteriorating performance at poor performer sites. Ranked the contractors under the DEFRA 2326 authority and recommended five potential replacement sites.

- HCFA negotiated changes to 80 Medicare prime contracts which included (1) an important new requirement that contracts segment pension costs, (2) a HCFA right to extend nonrenewed contracts for an additional 6 months to effect smooth transitions, and (3) an electronic transfer of funds provision to replace the antiquated letter of credit system. All of the changes became effective October 1, 1987.

- In FY 1988, HCFA will review 165 PRRB decisions (including jurisdictional decisions), prepare 140 court actions and review 25 hearing Officer decisions. For FY 1989, HCFA will review 180 PRRB decisions (including jurisdictional decisions), prepare 150 court actions and review 25 Hearing Officer decisions.

- HCFA negotiated and reviewed 145 Health Maintenance Organization/Competitive Medical Plan (HMO/CMP) Tax Equity and Fiscal Responsibility Act (TEFRA) contracts. There were 158 TEFRA risk contracts at the end of FY 1987. The number of enrolles increased from 772,488 to 981,068.

- PRRB, in FY 1987, conducted 81 conferences, conducted 88 hearings, published 115 decisions, resolved 1,190 cases prior to hearings, managed an average of 3,000 active cases and prepared 4,387 letters/memoranda and notices related to appeals before the Board.

- HCFA implemented the following Omnibus Budget Reconciliation Act of 1986 provisions:

  - Optional coverage groups for poor pregnant women and children and disabled and elderly with incomes up to 100 percent of Federal poverty levels.

  - Claims Processing Timeliness Standards.

  - Coverage of Physician Assistants, Optometrists, and Occupational Therapists.

  - Physician payment changes including a new physician monitoring program for the Maximum Allowable Actual Charge Limits.

  - Intermediary support for medical review of HMO quality of care.

  - Periodic Interim Payment System for DRG hospitals and prompt payment for Medicare providers.

  - Payments for hospital capital-related costs.

  - Payments for ambulatory surgery - HCFA common procedure coding system for hospital outpatient services; rebundling of hospital outpatient services; revising payment method for ambulatory surgery performed by hospitals.

  - Payments for home health services - rebased HHA cost limits in the aggregate rather than by discipline, and provided an add-on to take into account the cost of billing and verification procedures.

  - Report to Congress on intermediary denials and presumptive waiver of liability for HHAs, SNFs and hospices.

- HCFA will review about 500 separate actions involving State Medicaid Long-Term Care Reimbursement plans and Alternative Hospital Reimbursement plans.

- PRRB, as part of its responsibility to hear cost reimbursement and prospective payment disputes between providers and intermediaries, plans to establish 2,000 cases for hearings, manage 3,500 active cases, resolve 1,100 cases prior to hearing, conduct 120 hearings, and render 130 decisions. PRRB also plans to conduct 150 conferences and prepare 6,500 letters, memoranda, and notices related to appeals before the Board. PRRB has acquired a Computer System and is working toward implementing a management information system in 1988.

- HCFA will issue a mailing to 31 million beneficiaries on the availability of Medicare Participating Physician Directories (MEDPARD).

- HCFA will issue rules establishing prospective payment rates affecting about 1,000 hospitals for direct graduate medical education costs pursuant to section 1886(h) of the Social Security Act.

- HCFA will develop regulations to implement a number of technical changes to the PPS, cost limit and rate of increase limit rules.

- HCFA will issue new regulations to implement new legislation including necessary changes mandated by reconciliation legislation.

- HCFA will survey HMO/CMP disenrollees to determine the reasons for disenrollment.

- HCFA will administer a beneficiary tracking system which will record complaints from prepaid Medicare enrolles.

- Implement annual changes in PPS.

- Implement Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA 1985) provisions:

  - Unique Physician Identifier.

  - PRO Prior Approval Provisions for Assistants at Cataract Surgery and Certain Elective Procedures.

    - Return on equity capital-inpatient hospital services and other services.
    - PRO review of substandard care.
    - One hundred percent PRO preadmission preprocedure review of 10 selected procedures and installation of the second opinion program.

- HCFA mailed notices to 31 million beneficiaries on the 1987 premium rate and hospital deductible rate increases.
- HCFA completed the installation of telephone service monitoring equipment at all carrier locations, and implemented monthly carrier telephone service reports and feedback reports to HCFA regional offices citing carriers not in compliance with telephone service standards.
- Implement improved contractor medical and utilization review requirements.
- Manage contractor productivity investment and medical review budgets.
- Arrange and participate in four meetings with the Medicare Contractors Representative Group (CRG) in order to achieve consultation on broad policy issues.
- Continue the physician/supplier participation program:
    - Enroll/disenroll physicians/suppliers.
    - Print and distribute directories of participating physicians/suppliers to physicians, hospitals, PROs, senior citizen organizations, and beneficiaries upon request without charge.
- Develop standard contractor software systems.
    - Implement standard Part A systems in Michigan, Aetna, New Jersey, Puerto Rico, Kentucky, Washington and Alaska.
    - Implement standard Part B system in one site (pilot).
- Implement National Lab Fee Schedule Update.
- Improve instructions, provide training and assure the timely and accurate submission of Part B Medicare Annual Data.

- Ensure the timely installation of the 1988 HCFA Common Procedure Coding System update and continue to manage local code assignments.

- Improve PRO/fiscal intermediary (FI) systems coordination on denials.

- Implement HHA Screening Module in regional home health fiscal intermediaries.

- Implement medical review initiatives:

  - Physical Therapy Screens.
  - Revised HCFA 485 - 488 home health forms.
  - Provider/Beneficiary Profiling for home health services.
  - Comprehensive Outpatient Rehabilitation Facility medical review.
  - Monitoring of FI medical review.

- Continue to develop the Medicare common working file to allow for improved processing and payment safeguards. One pilot was installed in FY 1987 and another will be installed in FY 1988.

- Continue improvement in Intermediary and Carrier Systems Testing Projects.

- HCFA will develop and implement a monitoring protocol involving Central Office/Regional Office (RO) joint site visits to HMOs/CMPs to evaluate and improve compliance with medical contract requirements and HMO/CMP regulatory requirements.

- HCFA will develop operational guidelines for Medicare Preferred Provider Organization (PPO) proposal.

- HCFA will issue a revised Health Insurance Claim Form (HCFA 1500).

- HCFA will develop new procedures to effect maximum intermediary and carrier utilization of Government travel discounts.

2. Medicare/Medicaid Financial Operations

HCFA oversees the financial mechanisms in the Medicare/Medicaid programs in order to identify and curtail fraud, waste and abuse. Specific activities include:

- Preparation of the National budget to finance Medicare contractor activities; review and approve individual contractor budgets and budget amendments.

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- Monitoring of each Medicare contractor's financial operations, including review of expenditure plans, interim expenditure reports, final administrative cost proposals, banking agreements, subcontracts and leases.
- Monitoring the Medicare State Waiver Projects including the waiver payment simulation system and the Maryland Cost Per Admission comparison.
- Coordination of the clearance and resolution process for Office of the Inspector General Audit Agency (OIGAA) and General Accounting Office (GAO) audits of Medicare intermediaries, carriers, State Medicaid agencies, State Survey agencies, HMOs, PROs, and ESRD networks.
- Development of statistics/estimates on administrative costs of Medicare contractor/State Medicaid agency operations.
- Monitoring contractor audit performance (audit costs and savings) and establishing contractor audit priorities to maximize the effectiveness of audit funds invested, and to collect specific data necessary to respond to policy and legislative issues.
- Conducting disallowance and penalty activities resulting from external audits, HCFA financial reviews, Medicaid Eligibility Quality Control, utilization review, and State Performance Evaluation and Comprehensive Test of Reimbursement Under Medicaid (SPECTRUM) review Medicaid institutional reimbursement review section 1122 (unnecessary capital expenditures) denials.
- Monitoring of Medicare contractor/State Medicaid agency activities in the areas of overpayment identification and recovery, processing of uncollectible overpayments, all beneficiary overpayments, and reconsideration claims and hearings.
- Ongoing review of each State's Medicaid operations, including quarterly budget forecasts and quarterly expenditure reports.
- Review of Medicare contractor and State Medicaid agency implementation of institutional reimbursement policies to assure that providers claim only the proper amount for services rendered.

Major Highlights/Significant Accomplishments

- HCFA cleared 281 audits totalling about $139 million during FY 1987 and has plans to clear 233 audits totalling about $233 million in FY 1988 and 256 audits totalling about $256 million in FY 1989.

- HCFA increased its Medicaid financial management oversight by adding 20 additional Regional Office financial staff to perform financial management reviews and by supplementing this effort with reviews performed by outside contractors. During FY 1987, the financial management reviews identified $276.3 million in unallowable expenditures. Of this total, $122.4 million has now been recovered while the balance remains in dispute.

- HCFA reviewed and processed over 1,000 Medicaid budget (Form HCFA-25) and expenditure (Form HCFA-64) forms and issued over 800 related Medicaid grant awards. HCFA issued 73 disallowance letters totalling $221 million. Overall, HCFA was able to obtain approximately a $175 rate of return for each $1 of Regional Office financial management staff resources invested.

- HCFA directed and monitored the completion of four special data collection efforts to facilitate legislative and policy issues; two special data collection efforts involving 600 PPS-2 (second year under PPS) hospital cost reports, a review of 100 ambulatory surgical center cost survey forms, and audit of 124 ESRD facilities.

- HCFA developed and issued comprehensive guidelines to enhance provider audits, including a chain home office desk review program, chain home office field audit program, home health agency field audit program, and a Change of Ownership Manual for review of mergers and acquisitions.

- HCFA improved Medicaid Funding Management, reviewed and responded to 210 multi-OPDIV funding requests, initiated a tracking system for State implementations and streamlined the reapproval procedures for Medicaid Management Information Systems.

- HCFA will process 3,000 contractor financial documents. To ensure compliance with budget guidelines, HCFA will review approximately 1,000 forms HCFA-25/64 (Medicaid reports), totaling $830 million in cost avoidance/dollar savings, review 900 Medicaid cost allowance actions (including disallowances and voluntary adjustments) and prepare and issue 850 Medicaid grant awards.

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- HCFA will maintain Hospital Cost Report Information System cost data for 7,000 hospitals, 3,500 Skilled Nursing Facilities (SNFs) and 4,000 Home Health agencies (HHAs); process 1,300 hospital Prospective Payment System (PPS) processing exceptions; maintain ongoing ESRD and Ambulatory Surgical Center (ASC) program data and prepare annual results of implementation reviews.

- HCFA projects to obtain an overall return of $8 for each $1 of provider audit funds invested.

- HCFA will develop 101 Medicare contractor budget estimates and prepare 214 Medicare cost estimates.

- HCFA will develop four Medicaid budget estimates and produce an eight year cost projection for the entire Medicaid program.

- HCFA will develop 10 regional audit allotments, continue a tracking system for waiver States, develop a national contractor audit budget and complete a special PPS-1 (first year under PPS) audit effort.

- HCFA will remain actively involved in all aspects of the Administration's capitation/competition initiatives. Specific activities include major addresses before national industry groups, development of an HMO/CMP Task Force, and development of a Geographic Capitation workgroup. HCFA will also develop numerous legislative proposals to improve the Agency's ability to negotiate capitation programs. HCFA's participation was key in getting employers, unions and the insurance industry "to the table" to negotiate capitation demonstration projects. HCFA staff will also provide technical advice on capitation to key officials of the Administration, key industry representatives, and the Congress.

- HCFA will prioritize and monitor the results of approximately 8,000 provider cost report audits which will produce over $800 million in program savings.

- HCFA will direct and monitor special audit initiatives to resolve over 20,000 provider (cost report) claims resulting from changes in Medicare policy for malpractice insurance and labor/delivery room days; will perform 400 special audits to implement changes in payment policy for graduate medical education costs; will perform 300 special desk audits of Hospice cost reports to facilitate reports to Congress.

3. Medicare/Medicaid Agent Performance Assessment

The assessment of Medicare and Medicaid program agent performance provides for financial and programmatic accountability in these two programs; results in the identification and resolution of specific problem areas; and improves program efficiency through the reduction of erroneous program payments. Specific activities include:

- Performance evaluations of the Medicare contractors and the publication of results of these evaluations so that they can be used to identify erroneous payment trends, develop corrective action strategies, and identify exemplary practices.
- Development of contractor performance standards as mandated by the Medicare/Medicaid Anti-Fraud and Abuse Amendments of 1977, P.L. 95-142.
- Recommendations with respect to: (1) renewal or termination of individual Medicare contractors; and (2) sanctions or adverse actions against State Medicaid agencies or Medicare fiscal agents resulting from failure to meet performance criteria in various operational areas.
- Evaluation of State Medicaid Agencies' performance, identification of problems and recommendation of corrective actions concerning the operation of the Income and Eligibility Verification System (IEVS).
- Evaluation of Medicare contractor and State Medicaid agency programmatic ADP systems.
- Identification of program policies and instructions that require clarification or modification.
- Development and implementation of a System for Alien Verification of Entitlement (SAVE).

Major Highlights/Significant Accomplishments

- HCFA developed a new FY 1987 ranking methodology for use under section 2326 of the Deficit Reduction Act of 1984 (DEFRA). The methodology was also published in the Federal Register as notification of HCFA's intent to employ it in FY 1988.
- HCFA developed a new regulation allowing States more flexibility in using IEVS data as authorized by OBRA 1986. IEVS, Regional Office and State instructions were issued and 20 States were reviewed for IEVS performance and cost benefits.

- For FY 1988, HCFA restructured the Contractor Performance Evaluation Program (CPEP) to focus more on results oriented measures rather than process measures; redesigned the scoring mechanism to create a finer degree of scores for each standard while at the same time being less labor intensive on the part of the HCFA Regional Offices. The Regional Offices and the contractors assisted in the redesign of the FY 1988 CPEP.

- HCFA will continue to maintain the automated submission of the Medicare Intermediary/Carrier workload report to improve accuracy and timeliness; complete and review approximately 6,800 Contractor Performance Evaluation Program (CPEP) standards; and review and publish 106 Annual Contractor Evaluation Reports (ACER).

- HCFA will issue final SAVE regulations and prepare a report to the Congress on SAVE prospects.

4. Quality Control

The primary objective of this function is to maintain the fiscal integrity of the Medicare and Medicaid programs and to enforce health and safety standards. Specific activities include:

- Oversight of Medicare intermediary activities for both retrospective and prospective based reimbursement to providers including audits, settlements, interim payments, and rate determinations.

- Developing automated systems applications and database management for Medicaid and Medicare oversight.

- Evaluating samples of Medicare Part A and Part B claims to assess Medicare contractor performance in processing and paying claims.

- Reviewing State Medicaid determinations in the areas of reimbursement, eligibility, third party liability, and claims processing.

- Monitoring the medical and utilization review activities of Medicare contractors, State Medicaid agencies and Quality Control Peer Review Organizations (PRO and non-PRO).

- Introducing generic quality screens and mandating comprehensive evaluations of each case reviewed by PROs.

- Reviewing utilization and expenditure patterns of sample groups of hospitalized beneficiaries before and after PPS implementation to determine the need for changes in the oversight process.

- Develop, negotiate, maintain and modify contracts with Utilization and Quality Control Peer Review Organizations (PROs) for the medical review of care provided to beneficiaries.

- Develop generic quality screens to be applied by the PROs to each inpatient hospital case.

- Implement legislative provisions that impact on the PRO program.

- Improve the Peer Review Organization Monitoring Protocol and Tracking System (PROMPTS) under which PRO performance is evaluated, deficiencies are identified, and corrective action plans are formulated.

- Monitor and evaluate PRO performance.

Major Highlights/Significant Accomplishments

In the area of Medicaid oversight, HCFA activities included:

Medicaid Eligibility Quality Control (MEQC)

- Published MEQC final rule that makes MEQC revisions and developed accompanying instructions based on public comments.

- Worked with the Department to promulgate the Administration's position on quality control related legislation and to incorporate these positions into congressional bills.

- Implemented congressional changes to the MEQC system.

- Kept the MEQC manual current through regular, comprehensive updating.

- Revised regional requirements to reduce workload while maintaining statistical validity and targeting efforts on problem areas.

- Issued manual instructions establishing State transmitted Integrated Quality Control (IQC) findings as the official State MEQC findings.

- Conducted studies to obtain information necessary to fulfill the study requirements mandated by COBRA moratorium.

- Assisted in coordinating all aspects of Department's quality control moratorium report as mandated by COBRA.
- Provided information and cooperated with the National Academy of Sciences in preparing their quality control moratorium study mandated by COBRA.
- Provided briefing materials and made presentations to congressional staffs on quality control procedures and changes proposed as a part of the moratorium study.
- Cooperated with, provided information for, and testified before the Grant Appeals Board on MEQC policies/procedures.
- Issued error rate projections for all States for the fiscal year for all quarters after the effect of the revised eligibility moratorium had been determined.
- Provided instructions to States and Regional Offices on revisions to error rates for FY 1982-1986 based on Deficit Reduction Act (DRA) eligibility policy moratorium.
- Recalculated all FY 1982-1986 error rates to reflect the provisions of the revised DRA. Developed methodology and calculated prospective error rates for subsequent years.
- Developed and tested comprehensive MEQC training manual. Manual is effective in training contract personnel.
- Performed two oversight reviews of Regional Offices to assure compliance with proper quality control procedures.
- Established and maintained contact with the Department of the Treasury in order to determine the feasibility of a data match involving Medicaid recipients and U.S. Savings Bonds files.
- Reviewed State Corrective Action Plans to develop nationwide best practices/policies on efficient and effective corrective actions.
- Developed contract to complete approximately 2,000 MEQC re-reviews and to complete State reviews if a State fails to cooperate in completing a valid MEQC sample or

individual reviews required to make a projection of its error rate or determine its actual error rate.

- Monitored contract for re-reviews to assure national consistency.

National Integrated Quality Control Program (NIQCP)

- Worked with the Family Support Administration and the Department of Agriculture, Food and Nutrition Services, to continue development of an integrated QC system.
- Developed and implemented, along with HHS-FSA and FNS, an enhanced Integrated Quality Control (IQC) data entry and collection system for State data.
- Participated on IQC systems and program committees to develop refinements to program policies and to ensure corresponding systems capabilities.

Income and Eligibility Verification System (IEVS)

- Developed and published HCFA MEQC manual detailing procedures for using IEVS.
- Developed and implemented interagency agreement with Internal Revenue Service to obtain unearned income data to be used in the MEQC review activity.
- Updated IEVS requirements based on changes to statute.
- Developed various Regional Office and State instructions on implementing IEVS.
- Conducted onsite implementation reviews in 15 States.
- Conducted onsite safeguarding reviews in all States.
- Evaluated IEVS costs/benefits.
- Updated computer system for data entry of the integrated review schedule.
- Updated and published HCFA IQC manual detailing procedures for completing the integrated review schedule.
- Operated data link between Washington Computer Center, IQC data, and the HCFA Data Center to eliminate redundant regional keypunching of State MEQC findings.

Statistical Support

- Developed sampling plan data base structures and analytical products for the MEQC, Third Party Liability (TPL), System Performance Review (SPR), Claims Processing Assessment System (CPAS), Part A and B quality assurance, financial and operational review programs.
- Developed data collection systems for quality assurance programs either directly or through BOA contract.
- Provided technical support in legal challenges to statistical aspects of disallowance or program activities.
- Administered statistical consultant contracts to defend current programs or to develop enhanced or more efficient statistical samples and analyses.
- Developed system to collect System Performance Review claims, review information and compute error rates.

Utilization Control (UC)

- Analyzed 48 validation surveys.
- Reviewed 192 quarterly showings.
- Issued 15 UC penalties.
- Implemented penalty tracking/control system.
- Provided technical assistance to Regional Offices.
- Prepared briefing materials to regional attorneys for appeals to the Grant Appeals Board and district courts.
- Developed HCFA UC Manual detailing States' responsibilities in operating an effective UC program.
- Developed various Regional Office instructions on implementing and monitoring States' utilization control activities.
- Developed and published HCFA UC Penalty Status Report.
- Assisted in developing inspection of care training program for States.
- Developed and implemented pilot tests on States' corrective action in long-term care facilities, Federal

look-behind review, and two percent tolerance on inspection of care reviews.

Third-Party Liability (TPL)

- Monitored TPL review contract and amended scope of work to broaden review.
- Incorporated TPL review into System Performance Review for Medicaid Management Information System (MMIS).
- Monitored States compliance with TPL cost avoidance and data match regulations.
- Integrated TPL action plan with and monitored through the review of the Medicaid Management Information System (MMIS).
- Maintained databases on State TPL savings and practices.
- Marketed TPL to the States.
- Provided technical assistance to the regions.
- Worked with the Social Security Administration and the States in the area of 1634 agreements and collection of TPL data.
- Developed and monitored a contract to measure cost avoidance.
- Developed a review protocol with OSCE to review State IV-D and Medicaid operations in the TPL/Medical Support area.
- Published State "Successful Practices Guide".
- Wrote necessary regulations and manual issuances.
- Wrote semi-annual reports on Federal savings from TPL activities.

System Performance Review (SPR)

- Monitored Regional Office application of SPR in 45 States and the District of Columbia.
- Analyzed all SPR final reports.
- Produced a year-end final report for all Medicaid Management Information System States and made recommendations on enhanced funding reductions for all States which failed.

- Released revisions to Regional Office Manual to reflect legislative and program requirements.
- Continued development of a system to collect SPR claims, review information and compute error rates.
- Provided technical assistance to Regional Offices and States.
- Conducted training on the implementation of the revised FY 1987 SPR.
- Rewrote the SPR (using RO/CO workgroup) reflecting current management and policy positions to be effective in FY 1989.

Claims Processing Audit Program

- Modified audit triggers package to reflect FY 1987 SPR results.
- Published Program Memorandum to explain audit to State agencies.
- Applied audit triggers for selecting audit States.
- Selected two additional States to be audited.
- Monitored contract to audit States claims processing program.
- Reported to State and region on audit findings.
- Took disallowances on identified misspent funds.

Claims Processing Assessment System (CPAS)

- Developed summary report of FY 1987 findings and corrective action taken.
- Provided technical assistance to Regional Offices.
- Calculated payment error rates for States operating alternate and mandatory CPAS.

State Performance Evaluation and Comprehensive Test of Reimbursement Under Medicaid (SPECTRUM)

- Conducted SPECTRUM training session, revised program instructions, monitored the RO performance of 40 SPECTRUM reviews, and prepared a SPECTRUM analysis report. In FY 1987, SPECTRUM identified $101.4 million of Federal Financial Participation (FFP) overpayments to States.

Home and Community-Based Waivers

- Reviewed 81 HCFA-372 form (Annual Expenditure Report for Home and Community Based Waivers), the means by which States report expenditure and recipient data on their home and community-based waivers.
- Modified form HCFA-372 to incorporate OBRA 1986 legislative changes and drafted corresponding instructions to States.
- Developed the revised form HCFA-372 and obtained EOMB approval. This revised form eliminates the use of another form, HCFA-371, which the States previously were required to complete in addition to the form HCFA-372.
- Automated monthly workload report and developed automated listing of States 372 forms.
- Revised HCFA-372 and submitted to EOMB for continued approval.
- Implemented legislation changes in waiver program.
- Processed 107 HCFA-372s due in FY 1988 and an additional backlog from FY 1987 (38 HCFA-372s). The total processed workload, 145 HCFA-372s.
- Reviewed 10 Independent Assessments due in FY 1988.
- Conducted 49 onsite compliance reviews in 35 States.

With respect to Medicare quality control, HCFA activities included:

Part B End-of-Line (EOL) Review

- Implemented modernized Part B Quality Assurance program to provide better data for reduction of carrier overpayments and underpayments and to provide for more efficient collection of data through electronic transfer of data.
- Monitored operation of Part B Quality Assurance (QA) program at 51 carrier sites.
- Conducted Regional Office assessments to ensure consistent application of QA rules and procedures.

- Provided technical assistance to Regional Offices concerning Part B QA process.

- Produced four quarterly Part B QA reports.

- Provided technical assistance and intensively monitored program systems changes to Part B QA automated system to accommodate and monitor claims payment timeliness and interest payment provisions of recent legislation.

- Developed more effective methods for identifying claims processing deficiencies and increased efforts to improve claims processing performance.

- Monitored an independent national review of Parenteral-Enteral claims.

Institutional Payments

- Identified more than $6.5 million in recoverable overpayments to Medicare providers in FY 1987 through reimbursement review activities.

- Developed, implemented and managed, under the Uniform Contractor Evaluation Program (UNICEP), a series of review programs that are carried out by Regional Office staff to evaluate the efficiency and effectiveness of Medicare fiscal intermediaries in making payment to providers.

  (1) Test of Intermediaries' Prospective Payment Settlements (TIPPS) evaluates fiscal intermediary settlement of cost reports for PPS hospitals.

  (2) Quality Evaluation of Settlements under TEFRA (QUEST) evaluates fiscal intermediary settlement of cost reports for hospitals excluded from PPS.

  (3) Home Health Agency/Reimbursement Review Program (HHA/RRP) evaluates fiscal intermediary settlement of HHA cost reports.

  (4) Skilled Nursing Facility (SNF) Review Program evaluates fiscal intermediary settlement of cost reports for freestanding SNFs. (This program was initiated for FY 1988.)

  (5) Home Office Monitoring and Evaluation Program (HOME) evaluates fiscal intermediary audit activity for cost statements filed by home offices of chain organizations.

  (6) Initiate intermediary systems test program

(ISTP), and use it as a CPEP element for intermediary claims processing performance.

- Planned and implemented quality review for special audit initiatives to reopen hospital cost reports to recalculate allowable malpractice insurance costs.
- Planned and developed a methodology to improve the management of the review process and to assure that review focus will be proportionate to the resources expended on an activity.
- Initiatives for FY 1988 include a series of productivity enhancement strategies and inclusions of the reimbursement review programs in the Productivity Improvement Program.
- Conducted two quality reviews of major chain organization home office audits that have been performed by FIs.
- Developed a strategy for Medicare FI and Medicaid State agency coordination in auditing home offices of multifacility chain organizations, in order to gain economies of scale.

Part A Quality Assurance Review

- HCFA is conducting a second review cycle from October 1987 - March 1988. Fourteen FIs will review 500 PPS bills. The Regional Offices will review a 100 bill subsample for each FI.
- HCFA will review all remaining FIs (31) over the next 3 years (1-2 FIs per regional office per year).
- HCFA will implement and monitor corrective actions on erroneous situations discovered during the reviews to minimize future mispayments.

Contractor Performance Evaluation Program (CPEP)/Annual Contractor Evaluation Report (ACER)

- Revised CPEP implementation procedures to reduce workload requirements on Regional Offices.
- Developed and maintained a computerized system for submission of CPEP data which reduced duplicative reporting requirements and enabled Regional Offices to schedule CPEP reviews, manage the program, produce management reports and prepare ACERs by personal computers.

- Developed detailed instructions for Regional Office implementation of CPEP which formalized the appeals process and established documentation requirements.

Statistical Support

- Developed statistically valid samples for several national operational reviews.
- Developed simulation model to measure contractor telephone operations.
- Testified in provider appeal of audit based on statistical sample.
- Developed samples for Part A EOL "limited review".

Quality Control Systems

- Revised Medicare contractor workload reporting system to collect data on claims paid in select single day intervals and interest paid on late claims.
- Produced reports containing data concerning Medicare contractor workloads, assignment rates, providers receiving Periodic Interim Payment, Part B appeals, and other key operational data.
- Conducted Medicare Data Validation Reviews in contractor sites to improve quality of Medicare operational data.

Peer Review Organizations

- In FY 1987, HCFA began evaluating the performance of second round PRO contractors. The results of these evaluations will be used for renewal/nonrenewal decisions for the new contract cycle.
- PROs began implementing the preprocedure review to determine medical necessity for use of assistants at cataract surgical procedures based on complicating medical conditions.
- PRO review of ambulatory surgical procedures was implemented in the State of Pennsylvania in FY 1987.
- Negotiations were concluded with 51 organizations to conduct HMO/CMP review.
- PRO review of hospital readmissions and the post-hospital care rendered between the readmissions was implemented in the State of Pennsylvania.

- In FY 1988 and FY 1989 HCFA will negotiate 41 third round peer review contracts and 50 extensions to existing second round contracts.

- HCFA will review, negotiate and issue in excess of 1,500 modifications to PRO contracts.

- HCFA will begin PRO review of ambulatory surgery nationwide.

- A report to Congress will be developed, recommending other surgical procedures for which an assistant is not generally medically necessary.

- PROs will implement denial of payment for substandard care.

- In FY 1988, 100 percent PRO preadmission/preprocedure review of at least 10 selected surgical procedures will be implemented.

- HCFA will expand PRO review of hospital readmission to 31 days and implement nationwide review of interim care.

- PRO review of beneficiary complaints to cover care provided by such providers as SNFs and HHAs will be monitored.

Contractor Medical Review Operations

- HCFA initiated reviews of Part B Medical Review (MR) effectiveness of eight contractors during FY 1987 that resulted in suggested improvements that are anticipated to result in savings of over $4 million. Additional reviews will be initiated in FY 1988.

- Analyzed the use of prior authorization for home health services.

- Implemented home health coverage compliance review modifications.

- Refined the home health data set.

- Refined the review of outpatient/Comprehensive Outpatient Rehabilitative Facilities services.

- Refined review methodologies for carrier screens and parameters to implement the cost effective configurations.

- Prepared policy studies in support of the Contractor

Performance Evaluation Program (CPEP) responsibilities.

- Provided technical assistance to medical review agents and regional staff in writing in 250 instances and by phone in 1,500-1,700 instances.
- Evaluated, modified and maintained four program information systems.
- Prepared 350 "comments" regarding medical review policy including policy studies, program reports and technical issues.
- Developed medical review agent cost estimates.
- Provided technical assistance to medical review agents in 2,308 instances.
- Focused the Part B Medical Review Post Payment Process on the most aberrant providers.
- Strengthened the Part B Medical Review Policy Development process.

5. Operational Review Activity

HCFA has responsibility for operational reviews which assess the need for policy and operational reforms in vulnerable program areas. Specific activities include:

- Preparation of studies of selected program and policy issues through the review of in-house information, supplemented by additional on site documentation, to keep HCFA managers informed.
- Development of detailed review guides, special studies and summary issue papers.

Major Highlights/Significant Accomplishments

- HCFA completed 10 National Reviews and identified options for policy, operational or regulatory reforms. For example, reviews for FY 1987 included: (1) a national study of the medical necessity, and program coverage of hospital outpatient services being paid for under Medicare; (2) a national study of physician reimbursement for services associated with Transurethral Prostatectomies (TURPS); (3) an assessment of the nationally mandated Part B carrier screens and an evaluation of local carrier screens that may be worthwhile mandating as additional screens; (4) an analysis of the adjudicative process involved in PRO recommended denials which involve payment actions by Medicare fiscal intermediaries and carriers; and (5) the development of standardized global service packages around selected high volume surgeries and pricing of those packages across all carriers to allow valid comparisons across geographical areas.

6. Maintenance of Health and Safety Standards

HCFA is responsible for developing, implementing and enforcing statutory and regulatory Federal health and safety standards which stipulate specific structural requirements as well as quality of care conditions for approximately 44,000 Medicare and Medicaid facilities. Specific activities include:

- Development, analysis, and enforcement of standards for all providers and suppliers participating in the Medicare/Medicaid program.
- Evaluation of the performance of State survey agencies.
- Conduct of Federal validation surveys.

Major Highlights/Significant Accomplishments

- Published Hospital Mortality Rates to give Medicare beneficiaries needed information to make informed choices.
- HCFA Federal surveyors conducted approximately 1,505 validation and look behind surveys; conducted 53 State Agency Evaluation Program visits; prepared 34 Comprehensive Evaluation Reports; analyzed the result of 17,537 Medicare initial and recertification surveys and 11,538 Medicaid initial and recertification surveys.
- HCFA conducted 29 State surveyor training courses.
- HCFA developed a new long-term care survey process that focuses on the care actually provided and outcomes of care, instead of a facility's capability to provide services. Surveyors carefully observed and interviewed residents and conducted comparative record review in approximately 15,100 long-term care facilities.
- HCFA revised termination procedures for health care facilities that require immediate termination action when there is immediate jeopardy to patient health and safety. The procedures also require termination within

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90 days for noncompliance with other health and safety standards.

- HCFA implemented an intermediate sanction which results in denial of payment for new admissions instead of terminations in skilled nursing and intermediate care facilities. It is used when failure to meet participation requirements and deficiencies do not pose immediate jeopardy to patients.

- HCFA initiated actions to implement statutory requirement to reduce the existing 32 end stage renal disease networks to a lesser number to reduce administrative costs and to ensure quality performance. New network areas will be designed and contracts awarded on a competitive firm fixed-price basis for operational activities of the network organizations.

- HCFA evaluated the Institute of Medicine (IOM) study which analyzed the full range of nursing home regulatory and enforcement issues and provided recommendations for changes in the system. HCFA devoted effort to making changes to the areas of resident outcomes, quality of life and quality of care.

- HCFA developed a direct data entry system which will allow State survey agencies to enter the certification data into the Medicare/Medicaid Automated Certification System (MMACS).

- Develop and implement an outcome-oriented survey process for all providers, e.g., psychiatric hospitals, home health agencies, hospices, ambulatory surgical centers, and end stage renal disease facilities. (This will allow HCFA, for the first time, to link resource inputs to outputs and quality assurance activities to reimbursement in the area of long-term care.)

- Develop computer assisted training instructions. Courses will be designed to improve the skills and technical knowledge of surveyors. The courses will be participatory by design and task-oriented in content.

- Develop and implement new enforcement provisions for health care facilities to ensure the health and safety of patients, to significantly reduce program abuse, and to reduce overall administrative costs.

- Develop a management software system for the Medicare/Medicaid Automated Certification System that reflects current technology, is responsive to our needs, and has analytical capabilities.

- Strengthen the Regional Office role in the survey and certification process. The Regional Office would assume the role as "project officer," and would have the major responsibility in the oversight of 1864 Agreements to ensure that a State performs surveys and certification activities in an efficient and effective manner.

- Implement and further refine a national unit cost budget methodology to ensure consistency in formulating and allocating State certification resources from a national, regional and State standpoint.

- Develop a Uniform Needs Assessment Instrument that will be used to evaluate an individual's need for post-hospital extended services.

- Develop certification procedures and guidelines to be used by Organ Procurement Organizations to ensure compliance with requirements in order to receive organ procurement payments from Medicare and Medicaid.

- Develop instructions and forms to implement the ICF/MR correction and reduction regulation.

7. Regulations Development

Regulations are the vehicle for implementing legislative actions and Administration initiatives. In the current thrust toward streamlining reporting requirements and reducing program costs, the regulations development and review process plays a key role. In the conduct of this function, HCFA staff develop, review and clear regulations, manual instructions, guidelines, and other policy documents.

Major Highlights/Significant Accomplishments

- HCFA reviewed 78 non-HCFA regulations, prepared regulatory analyses, briefing outlines, status reports, responses to the Department and Executive Office of Management and Budget (EOMB) comments, maintained public comments and summaries of public comments, and coordinated briefings in FY 1987.

- HCFA prepared 273 regulations documents for clearance and submission to the Department, published 91 regulations, and prepared necessary operating instructions for contractors and institutional providers in FY 1987.

- HCFA published an NPRM to implement a new payment methodology for ambulatory surgical procedures

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performed by hospitals on an outpatient basis, as authorized by section 9343(a) of OBRA (P.L. 99-509).

- HCFA published a final regulation eliminating the exception to the routine cost limits for newly established home health agencies. This change is effective for cost reporting periods beginning on and after July 6, 1987. HCFA believes that a distinct exception for new HHAs is no longer valid.
- HCFA published a final regulation in accordance with section 9315 of OBRA 1986 to provide a revised schedule of limits on home health agency costs that may be reimbursed under Medicare for cost reporting periods beginning on and after July 1, 1986, and before July 1, 1987. In addition, this regulation provides an updated schedule of limits for cost reporting periods beginning on and after July 1, 1987.
- HCFA published a final regulation to implement a new payment methodology for ambulatory surgical procedures performed by hospitals on an outpatient basis as authorized by section 9343(a) of OBRA (P.L. 99-509).
- HCFA published an NPRM to implement limitations on the valuation of assets under the Medicare and Medicaid programs as authorized by section 2314 of the Deficit Reduction Act of 1984 (P.L. 98-369).
- HCFA issued form HCFA 2540S-87, Low Volume Freestanding SNF Cost Report for SNFs Electing Payment Under and Prospective Payment Methodology for Low Volume SNFs.
- HCFA will issue a revision to the Hospital and Hospital Complex cost report (form HCFA 2552-85) instructions to add supplemental instructions for payment of outpatient surgical procedures. The revision implements section 9343 of OBRA (P.L. 99-509).
- HCFA will publish a final regulation with a comment period to implement the elimination of the Periodic Interim Payment (PIP) system under certain conditions as authorized by section 9311 of OBRA (P.L. 99-509).
- HCFA published a revised schedule of limits on skilled nursing facility routine service costs that are paid under Medicare. This schedule applies to cost reporting periods beginning on and after October 1, 1987.
- HCFA will prepare regulations to update the schedule of cost limits for both HHAs and SNFs. In addition, we will issue regulations and updated rates for the

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prospective payment system for low Medicare volume SNFs.

- HCFA will develop a methodology for hospitals to submit their cost reports in an electronic format (versus hard copy cost report) to their fiscal intermediaries.

- HCFA will prepare about 160 regulations and notices for publication in the Federal Register. Most notable amongst these will be PPS regulations, direct medical education, conditions of participation for ICFs/MRs and Medicare recovery against third parties. We will implement 1987 Reconciliation. Virtually all of these regulations require extensive briefings of the Administrator, Under Secretary, Secretary, and key industry and congressional staff. Additionally HCFA will respond to over 38,000 pieces of mail, and 700 Secretary and Administrator letters. HCFA will review 270 Medicaid reimbursement plan amendments, 90 Home and Community-Based waivers, 73 Freedom of Choice waivers, 175 formal Regional Office requests for policy guidance, 64 manual issuances, 21 Congressional Status reports, and 89 Freedom of Information Act requests.

- HCFA will develop final rules to implement certain recommendations of the Institute of Medicine concerning conditions that long-term care facilities must meet to participate in Medicare and Medicaid. Except where different requirements are imposed by law, we would consolidate requirements into a single set of conditions for SNFs and ICFs focusing on facility performance rather than compliance with procedural requirements and emphasizing outcomes rather than process.

- HCFA will develop proposed changes to the methodology for determining the Medicare economic index.

- HCFA will develop regulatory options for improving the home health benefit.

- HCFA will develop a proposal to eliminate Medicare payment for kidneys sent to foreign countries or transplanted in non-Medicare beneficiaries.

8. Research, Demonstration, Statistical and Actuarial Analysis

This function provides knowledge about the basic structure, incentives, costs and effects of HCFA programs and policies and makes it possible to refine existing policies, simulate or test various changes on a trial basis, and develop innovative financing and delivery systems.

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- Development and conduct of research, demonstration and evaluation studies of the impact of HCFA programs on health care costs, program expenditures, beneficiary access to health care services, the quality of care provided to beneficiaries, and the economics of the health care industry.
- Creation of new and improved analytic data sets to support these ongoing research and demonstration activities.
- Development and conduct of congressionally mandated studies and preparation of congressionally mandated reports.
- Operation of a comprehensive Medicare Statistical and Decision Support System (MSDSS) to support the needs of intra and extramural research, actuarial analyses and program evaluation and description. The MSDSS includes complete information on beneficiary enrollment and utilization, and provider identification, certification, payment and cost data.
- Dissemination of research findings through reports and publications, and recommendations for legislative and regulatory changes based on empirical evidence obtained from studies.
- Creation of the organization specific beneficiary identification and utilization experience data sets necessary to support capitated demonstrations including Medicare Insured Group (MIG), Private Health Plan Option (PHPO) and PPOs.
- Development and implementation of a comprehensive person-based statistical data base (MEDSTAT) for Medicaid for selected States.
- Preparation of Trustees' reports on the status of Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) Trust Funds.
- Preparation of Medicare and Medicaid budget projections.
- Preparation of estimates of the cost of legislative and regulatory changes for the Medicare and Medicaid programs.
- Preparation of economic price indices in order to evaluate payments to Medicare providers under PPS.
- Development of final national Adjusted Average Per Capita Cost (AAPCC) ratebooks.

- Preparation of historic estimates and projections of national health expenditures.

- Collection, maintenance and dissemination of Medicaid data and providing of technical assistance and consultation to users of the data.

- Providing actuarial and economic consultation and assistance to EOMB, Congress, and States, as well as within HCFA and HHS.

Major Highlights/Significant Accomplishments

- HCFA currently is managing 332 ongoing extramural and intramural research/demonstration projects. HCFA will monitor, provide advice on, and analyze the results of these projects.

- In FY 1987, HCFA prepared 574 executive summaries and technical reports; prepared 12 requests for contracts; prepared 55 program statistical and evaluation reports and 26 intramural research reports. In addition, HCFA presented 21 research papers, chaired research sessions, sponsored conferences, and prepared special reports.

- In FY 1987, HCFA undertook studies to respond to 22 mandates under the Omnibus Budget Reconciliation Act of 1986.

- In FY 1987, HCFA had one solicitation planned for cooperative agreements and grants. This is the annual general solicitation (which includes two cycles - a discretionary funds cycle and a waiver-only cycle). Panels were convened to review and evaluate the applications received and awards will be made. In FY 1987, 172 proposals were received as a result of the general solicitation and 22 awards were made.

- HCFA submitted 11 mandated reports to Congress during FY 1987:

  - Alternative Methods of Reimbursement for Home Health Services

  - All Payors/Cost Shifting

  - Medigap

  - HMO (Medicaid)

  - 1985 Annual PPS Impact Report (Impact of PPS on Blood Banking Industry)

  - DRG Refinement
  - Radiologists, Anesthesiologists and Pathologists
  - HMO Interim
  - Physician Directed Clinics
  - Paying Physicians
  - AFDC Homemaker/Home Health Aides

- HCFA developed a data resource center, an inventory of available Medicare/Medicaid program data which is made available for both intramural and extramural research. A data system has been put into place to monitor and report on waiver costs associated with demonstration projects. A Local-Area Network-Based Management Information System is being developed to allow more efficient management of and access to administrative and project information.

- Approximately 2,888 written responses to public and Congressional inquiries were prepared in FY 1987.

- HCFA provided statistical analyses of health care data reliability, impact analyses on legislative or regulatory proposals, user tape files, multi-purpose software.

- HCFA provided an interpretation of health data statistics and information for decision-makers and developed Diagnosis-Related Groups (DRG) payment rates.

- HCFA has implemented regulatory and legislative changes to the PPS Payment Software (PRICER) provided to the fiscal intermediaries in their claims processing systems.

- HCFA developed a Medicaid statistical database (MEDSTAT) that provides for selected States (17):

  - All Claims Paid for by Medicaid
  - Person-Based Utilization Data
  - Eligibility Specific Data
  - State Summary Data such as the HCFA-2082
  - State Medicaid Program Characteristics
  - Eligible Populations and Subgroups
  - Medicaid Provider Specific Data

- HCFA created a Linked Part A and Part B utilization database including information for 100 percent of the Medicare population for CY 1984 to present. This data

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base will be the primary internal resource for quality of care/outcome studies, Private Health Plan Option (PHPO) demonstrations and for PRO review of early readmissions.

- HCFA will work on the development of new health care delivery and payment concepts in coordination with other government components and outside experts. Concept papers will be prepared.

- In FY 1988 and FY 1989, we plan to prepare, respectively, 14 and 8 Requests for Contracts to be published in the Commerce Business Daily. These contracts will be awarded for the undertaking of new research and demonstration projects. Panels will be convened to review and evaluate the proposals received, and awards will be negotiated. In FY 1987, 15 new contracts were awarded.

- Interim and final reports on existing projects will be prepared, and legislative recommendations will be made.

- Reports planned for submission in FY 1988 include:

    - Excluded Hospitals
    - Home Health Identifying Individuals at Risk
    - Certified Registered Nurse Anesthetists
    - Social HMO
    - Study of ACR/AAPCC (Adjusted Average Per Capita Cost)
    - 1986 Annual PPS Impact Report (Report on Quality of Post-Hospital Care)
    - Development of Prospective Payment Methodology for Outpatients (Interim)
    - Study of Renal Services Payment Rate (Interim)
    - Geographic Cost Index
    - Study of Payment Rates for Physician Assistants
    - Refinement of Prospective Payment System
    - Review of Standard for Medicare C.O.P.
    - State Utilization Review Systems

  - 1987 PPS Annual Impact Report (Report of Quality of Post-Hospital)
  - Study of Payment for Administratively Necessary Days
  - Study to Develop a Strategy for Quality Review and Assurance
  - Prior and Concurrent Authorization Demonstration
  - Development of Prospective Payment Methodology for Outpatient Services
  - Demonstrations of Preventive Health Services Under Medicare (Interim)
  - Home Health Services (Alternative Reimbursement Methodologies)
  - Impact of Outlier and Transfer Policies on Rural Hospitals
  - Swing Beds
  - Clinical Social Workers
  - Rural Teaching Hospitals and Referral Centers
  - Uncompensated Care
  - Urban-Rural Issues
  - Sole Community Hospitals
  - Impact of State Rate Setting Systems

- Reports planned for submission to Congress in FY 1989 include:
  - Relative Value Scales
  - 1988 PPS Annual Impact Report (Report of Quality of Post-Hospital Care)
  - Health Maintenance Organization - Disenrollment Study (Final)
  - State Utilization Review Systems
  - Rural Secondary Specialty Demonstration Project

- HCFA plans to serve as fiscal intermediary for eight demonstration projects and the Migrant Hospitalization

Program disbursing $30.9 million in benefit payments, processing 330,197 claims and settling 37 cost reports. Four hundred providers are involved in activities with this function.

- Project findings, health care delivery and financing research, program statistics, and information to support budget/appropriations and legislative initiatives will be disseminated in 1987 through HCFA publications including: The Health Care Financing Review (five issues in FY 1987), The Status Report, The Medicare/Medicaid Data Book, The Health Care Financing Notes (four issues in FY 1987), The HCFA Data Compendium, Health Care Spending Bulletins, the ESRD Research Report, and various special reports and working papers.

- Project findings and other health care delivery and financing research will be disseminated through the following HCFA publications: the Health Care Financing Review (five issues in FY 1988), the Status Report published annually, the Medicare/Medicaid Data Book published annually, and various special reports and working papers.

- HCFA will develop Executive Information Systems to meet the needs of Senior Staff; the first applications include PPS monitoring information and a complete overview of program statistics. Future applications may include program operation statistics and HMO/CMP management information.

- HCFA will prepare 25 speeches/talking points/briefings; and attend approximately 120 meetings.

- HCFA plans to expand the Medstat database to include 26 States. A review is underway to develop a comprehensive Medicaid data set for possible implementation in FY 1990 that would include all States.

- HCFA cooperates fully with various components within the Department; e.g., Social Security Administration (SSA), Public Health Service (PHS), in the development of combined research projects. Current research activities include support to PHS in: the National Medical Expenditures Survey (NMES), the consolidated ESRD Patient Registry, and the National Cancer Institute Studies; and support to SSA in: Beneficiary Disability Study and the New Beneficiary Study.

- HCFA co-chairs, with National Center of Health Statistics (NCHS), the ICD-9-CM Coordination and Maintenance Committee which is responsible for updating and clarifying the codes and instructions used in coding inpatient diagnoses and procedures. This committee has been very successful in meeting the needs of the Agency to refine the DRG system and in responding to the interests of the community to recognize changes in medical practice and new technologies.

- HCFA will fully automate the receipt of all SNF HCFA 2540S cost reports and also has created a data base to include data from all of these reports.
- HCFA implemented a Data Administration function to catalogue all data and information systems within the Agency. Additionally, HCFA has organized and chartered the Information Strategy Council, a Senior Staff level committee, to ensure that our information management strategy is in synchrony with the Agency's policy and program development agenda.
- HCFA will disseminate national cost estimates, descriptive information and analytic research findings through DHHS press releases and publications such as the HCFA Review; develop, update, and publish market baskets and other analytical factors used in updating PPS, physician reimbursement, and other provider rates in the Federal Register.
- HCFA will present Medicare cost estimates in Federal Register notices and prepare two Trustees' reports, five budget exercises, five program rates and numerous estimates for legislative proposals and administrative regulations.
- HCFA prepared 300 Medicaid cost estimates and 350 Medicaid statistical data tables, performed 200 technical consultations and 3,200 major statistical consultations concerning Medicaid data.

9. Program Management Systems Development and Maintenance

This function maintains the Medicare/Medicaid information bases on entitlement, premiums, deductibles, utilization, provider certification, and other operational items. It also involves the assessment of programmatic ADP systems. Specific activities include:

- Operation of the Medicare ADP systems that maintain beneficiary entitlement and utilization records; and maintenance of the data files on provider certification, SMI premiums collections and group health plan enrollments.

- Development, implementation and management of a system incorporating monthly receipt and editing of PRO electronic data submissions for management of PRO contracts and telecommunications of PRO data to Regional Offices databases.

- Operation of other program systems which support many of HCFA's major cost control activities (e.g., MEQC).

- Electronic processing and issuance of Medicare cards, Part A utilization notices, and Part B benefit explanations.

- System performance reviews of Medicaid Management Information Systems.

- Development of recommendations on proposed acquisitions of EDP hardware/software by Medicare contractors.

- Operation of the State Buy-In Program for Medicare/Medicaid eligibles, maintenance of the buy-in master file, and the billing and collection of approximately $42 million per month for SMI premiums under State Buy-In.

- HCFA has initiated a Workload Management System to assure coordinated management planning for contractor implementation of Medicare program changes. The system prioritizes new contractor tasks while ensuring that funding issues are addressed, and that clear instructions are issued providing contractors with adequate implementationlead time. A report is issued periodically to all contractors to advise them of current tasks in the system and their relative priorities.

- Develop, test, and disseminate to fiscal intermediaries updated software modules to include:

  PRICER to calculate FY 1988 prospective payment prices for acute care hospitals, an updated PS&R to produce provider statistical and reimbursement reports, a new ASC-PRICER which produces comparable ambulatory surgical center prices for selected outpatient surgeries, a new outpatient code editor (OCE) and updated modules for GROUPER which determines diagnostic related groups (DRG) and inpatient Medicare Code Editor which audits certain diagnosis/procedure/sex/age combinations.

- Development of hospital payment rates, DRG weights and outlier thresholds used to pay hospitals under PPS.

- Development and update of hospital level wage indexes used in hospital, SNF and ESRD reimbursement.
- Development of a Consolidated Part B System to replace three different existing systems, while enhancing the utility of the Part B data.
- Oversight and maintenance of ADP system providing financial utilization and membership statistics on all Federally qualified HMOs including those with Medicare risk contracts. Reports are provided for internal HCFA use and for the general public.

Major Highlights/Significant Accomplishments

- In FY 1987, 300 personal computers were acquired, installed, and 1,220 users trained through 60 ADP training sessions.
- HCFA reviewed approximately 90 regulations, prior consultations, manual revisions, and OIG/GAO reports.
- In FY 1987, HCFA expanded the State agency data entry function.
- HCFA developed and refined a system to interface Medicaid Eligibility data with Medicare Eligibility data in FY 1987.
- HCFA will record and diary 39,000 certifications for Medicare and Medicaid participation.
- HCFA will develop and maintain four procedure manuals for clerical personnel to process hard copy workloads, conduct studies and prepare reports for 12 projects.
- HCFA will review and approve 600 contractor/State requests for system changes, review 78 contractor systems, conduct 22 carrier and intermediary system testing projects, and evaluate 25 HCFA ADP systems.
- HCFA will process 85 hardware/software service procurements and 12 fiscal agent procurement documents, monitor the completion of 33 risk analyses and 33 contingency plans at contractor sites and develop and release annual Prospective Payment pricing module to Part A Contractors.
- HCFA will conduct annual reviews of States with a certified Medicaid Management Information System to determine whether the systems are operating according to Federal guidelines and develop and issue annual instructions to contractors to streamline operations and reduce administrative costs while maintaining

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program integrity. In addition, HCFA will issue Claims Processing Assessment System performance instructions, prepare Systems Performance Review reports and approval/disapproval letters, develop and/or revise regulations, manual instructions and guidelines and make initial certification on State MMIS systems.

- HCFA will disseminate approximately 5,000 HMO statistical reports to the HMO industry and general public. Reports will cover financial utilization and membership data submitted by HMOs on a quarterly and annual basis.
- HCFA is implementing the Project to Redesign Information Systems Management (PRISM). This effort will result in a significant upgrading of HCFA's hardware and software capability, including:
    - Acquiring and installing the ADP and data communications hardware in the HCFA Data Center (HDC) -- in FY 1987 this included a 30 million instruction per second CPU and 30 billion bytes of online storage.
    - Acquiring End User Computing (EUC) capability based on a personal computer (PC) and office minicomputer configuration.
    - Managing the Advanced Technology, Inc., contract to complete the systems redesign portion of our applications software development effort.
    - Expansion of ADP Training program to meet PRISM/EUC needs.
- HCFA will install a Value-Added Network and Hyper-Channel to improve telecommunications and data communications systems throughout the Agency.
- HCFA will expand an ADP Facilities Management Contract to handle increased workloads.
- HCFA will install Job Accounting and implement a revised Chargeback System for ADP central processing usage.
- HCFA will receive and edit up to 1,188 PRO reports each month, distribute the data on a network for Central Office PRO management and communicate the data within 24 hours to Regional Offices for analysis by project officers.
- The Contractor Workload Management System will be issued quarterly, will annotate critical tasks, include

all contractor instructions and ensure funding and lead time are addressed.

10. Program Instruction/Technical Assistance

This function embodies the responsibility for communicating HCFA's program policies and procedures to beneficiaries and providers and ensures uniformity in treatment of Medicare/Medicaid coverage, eligibility and reimbursement issues, resulting in reduced administrative costs. In addition to ensuring compliance with all relevant laws and regulations, technical assistance provides a vehicle for the resolution of operating problems identified by GAO, health care providers, or program beneficiaries. In performing this function, HCFA staff:

- Develop, issue and maintain policy interpretations and revisions of manuals used by contractors, State agencies, providers and Social Security field offices.
- Develop and issue requirements for processing Medicare/Medicaid claims.
- Provide technical assistance to State Medicaid agencies and Medicare contractors.

Major Highlights/Significant Accomplishments

- HCFA completed approximately 7,800 pages of manual instructions which involved 425 instructions to States, contractors and providers on Medicare and Medicaid operations; developed and issued new parts to the Peer Review Organizations Manual (232 pages); updated and reformatted into the new structured format the Program Operations Manual for Social Security Field Officers (316 pages) in FY 1987.
- HCFA plans to complete approximately 7,500 pages of manual instructions which involve approximately 425 instructions to States contractors and providers in FY 1988.
- HCFA will participate in 21 contractor visits and 25 task force groups.
- HCFA will refer approximately 25 issues to HCFA Physicians' Panel, refer approximately 10 issues to the PHS, resolve issues on which "reasonable and necessary" decisions have been made subsequent to PHS recommendations, and develop, evaluate and maintain program guidelines on coverage issues.
- HCFA will improve HHA medical review by developing an

automated Home Health Screening module and developing uniform Electronic Media Claim (EMC) formats.

11. Legislation and Congressional Affairs

This function encompasses support to the Secretary, the Assistant Secretary for Legislation (ASL), the HCFA Administrator and HCFA Senior staff, in planning and managing legislative operations of the Agency, in addition to serving as the main contact with ASPE and ASMB for proposed budgets. It provides the capability for responding to congressional legislative initiatives related to health care financing programs and maintains liaison with the Congress on legislative and budget proposals affecting these programs. In addition, the function includes legislative and policy development through the performance of policy-relevant studies of health care financing issues and the review and development of legislative budget proposals. Specific activities include:

- Plan and coordinate (with ASL) congressional briefing sessions and prepare congressional hearings to promote understanding and acceptance of HCFA objectives.
- Provide technical assistance to the Department and Congress during Committee mark-up of proposed legislation and other congressional activity on HCFA programs.
- Manage development of President's budget/legislative proposals for Medicare/Medicaid.
- Analyze legislation introduced in Congress that may affect HCFA programs.
- Prepare testimony, briefing books, materials and reports on congressional issues.
- Assist in development of agency, Department, and Administration positions on bills introduced in Congress.
- Conduct briefing sessions for HCFA officials and congressional staff.
- Provide legislative research and information services, including management of HCFA's legislative reference library, to HCFA staff.
- Perform long and short-range policy analyses in such areas as prospective payment systems; Medicaid coverage and eligibility; long-term care alternatives and physician reimbursement reforms; capitation and quality of care.

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- Provide technical assistance to congressional committees, individual members offices and other HCFA components on catastrophic health issues.

- Provide for the exchange of information between HCFA and Congressional staff on agency programs and initiatives.

- Respond to correspondence from Congressional Members and staff, public and private agencies, and the general public.

Major Highlights/Significant Accomplishments

- HCFA responded to more than 4,800 Congressional staff telephone inquiries concerning HCFA programs, e.g., implementation of the catastrophic program, and will respond to approximately 5,500 telephone inquiries in FY 1989.

- HCFA prepared at least 18 major analytical papers and over 250 short-term descriptive analysis papers on major policy issues of concern to HCFA, the Department, the Congress and the White House.

- HCFA prepared 135 legislative proposals in A-19 format representing changes to the Medicare and Medicaid programs; provided detailed specifications for approximately 150 proposals requiring legislative drafting; work with OGC in drafting four major bills incorporating the President's legislative program for submission to Congress.

- HCFA prepared technical briefing materials for HCFA staff, Departmental staff and the Congress; performed policy analyses of regulatory initiatives; provided over 300 workdays of technical assistance to Congress on HCFA-related legislation and provided analytic support for the Department's efforts on expanding private financing of catastrophic long-term care expenses.

- HCFA was requested to prepare 150 reports of Department position on major bills introduced in Congress.

- HCFA reviewed and developed positions on over 300 provisions considered by Congress during their budget reconciliation process.

- HCFA planned and developed supporting materials for over 40 Congressional hearings including the preparation and clearance of testimony for HCFA and

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Departmental witnesses in addition to coverage of other hearings relevant to HCFA, Departmental or agency concerns and preparation of 30 reports for senior staff; prepared over 700 briefing books for participating officials; conducted over 100 briefing sessions for witnesses and support staff; prepared materials for the record and hearing reports; planned and participated in over 275 meetings with Congressional staffs on program issues.

- HCFA responded to over 600 requests for reference materials, logged and monitored over 2,500 items of correspondence and entered over 1,500 legislative items, Congressional reports and reference documents into the database system. HCFA responded to more than 170 Congressional letters in FY 1987.
- HCFA provided the HCFA Data Compendium, FY 1989, a comprehensive overview of program statistics and information on Medicare and Medicaid, to numerous Congressional committees and staffs.
- HCFA prepared at least 25 bill summaries and bill reports on legislation related to Medicare and Medicaid.
- HCFA will prepare at least 15 to 20 major analytical papers and over 275 short-term descriptive analysis papers on major policy issues of concern to HCFA, the Department, the Congress and the White House.
- HCFA will prepare 100 to 125 legislative proposals in A-19 format representing changes to the Medicare and Medicaid programs; provided detailed specifications for approximately 55 proposals requiring legislative drafting; work with OGC in drafting four major bills incorporating the President's legislative program for submission to Congress.
- HCFA will prepare technical briefing materials for HCFA staff, Departmental staff and the Congress; performed policy analysis of regulatory initiatives; provided over 330 workdays of technical assistance to Congress on HCFA-related legislation and provided analytic support for the Department's efforts on expanding private financing of catastrophic long-term care expenses.
- HCFA will be requested to prepare 165 reports of Department position on major bills introduced in Congress.
- HCFA will review and develop positions on over 330

provisions considered by Congress during their budget reconciliation process.

- o HCFA will plan and develop supporting materials for over 44 Congressional hearings including the preparation and clearance of testimony for HCFA and Departmental witnesses in addition to coverage of other hearings relevant to HCFA, Departmental or agency concerns and preparation of 35 reports for senior staff; prepare over 880 briefing books for participating officials; conduct over 130 briefing sessions for witnesses and support staff; prepare materials for the record and hearing reports; plan and participate in over 250 meetings with Congressional staffs on program issues.

- o HCFA will respond to over 660 requests for reference materials, log and monitor over 2,500 items of correspondence and enter over 1,650 legislative items, Congressional reports and reference documents into the database system. HCFA will respond to more than 187 Congressional letters in FY 1989.

- o HCFA will provide the FY 1990 HCFA Data Compendium, a comprehensive overview of program statistics and information on Medicare and Medicaid, to numerous Congressional committees and staffs.

- o HCFA will prepare at least 110 bill summaries and bill reports on legislation related to Medicare and Medicaid.

12. Program Communications and Beneficiary Services

Communications and services to the nearly 32 million Medicare beneficiaries, more than 23 million Medicaid recipients, and the organizations, health care providers and institutions affected by those programs, as well as to the general public, represent a complex task of critical importance to the agency and considerable expense. The bulk of these activities involve explaining the programs to beneficiaries and recipients so they can avail themselves of their rightful benefits, but also required of the agency are detailed responses to inquiries requiring interpretation or clarification of laws, regulations and program guidelines, impacting on large numbers of beneficiaries, providers and institutions and involving significant amounts of program dollars. Public information activities also promote beneficiary and public awareness of cost-effective health practices. Liaison activities with health care organizations, State and local governments and other interested parties also serve to alert the Administrator to sensitive/critical situations. In performing these functions, HCFA staff:

- Respond to written and telephone inquiries from the general public, Congress, the White House, Social Security offices, carriers, intermediaries, organizations, and the news media.

- Prepare and distribute press releases, radio and television public service announcements, films, audiovisual presentations on videotape and in slide shows, handbooks and descriptive publications, and information mailings to beneficiaries.

- Conduct press briefings and educate the news media to the nature of the Medicare and Medicaid and health care financing issues being addressed by HCFA, thus promoting public knowledge of health care financing problems likely to confront individual families and how HCFA programs help solve them.

- Provide official documents to requesters under the terms of the Freedom of Information Act.

- Monitor the news media and alert the Agency to potential areas of public misperception, concerns or dissatisfaction.

- Review proposed disallowances of Federal matching funds.

Major Highlights/Significant Accomplishments

- HCFA received and responded to approximately 30,882 inquiries and received, routed and controlled another 26,035 pieces of correspondence during FY 1987.

- HCFA received, routed, controlled and reviewed approximately 18,090 inquiries under Congressional/White House correspondence in addition to 715 assignments in FY 1987.

- HCFA will respond to 34,665 written and telephone general public inquiries, prepare eight pieces of press materials, produce four television public service announcements, respond to five press inquiries, work with private producers in the preparation of six videotape productions for elderly audiences, prepare approximately 55 speeches for the Administrator and Senior Staff, prepare two slide presentations for use by HCFA and SSA staff with community organizations, and prepare and publish 26 publications for the general public and beneficiary audiences.

- HCFA will process an estimated 66,000 Freedom of Information requests, publish a new regulation to reflect changes in the FOI statute, revise the disclosure portion of the carrier and intermediary manuals, and conduct training in most Regional Offices for appropriate HCFA and contractor staff.

- o HCFA will conduct an appropriate public information campaign to inform Medicare beneficiaries of catastrophic health insurance coverage (assuming the law is enacted), including use of a national telephone hotline for beneficiaries, radio and TV public service announcements, mailing of a descriptive brochure to all Medicare beneficiaries, appropriate revision of the Medicare Handbook, and preparation of a kit of materials for use by the news media.

- o HCFA will continue public information campaigns in selected cities to inform Medicare beneficiaries of options available to them under the program, including use of prepaid health plans, availability of second opinions, use of physicians who take assignment, and other choices that help beneficiaries and the program in holding down medical care costs. Emphasis is on ensuring competition that fosters quality protection as well as cost economy.

13. Administrative Support

This function embraces many responsibilities mandated by law, regulation or external sources, such as the Executive Office of Management and Budget, Department of Treasury, Office of Personnel Management or General Accounting Office. Specific activities include:

- o Formulation and management of the program and administrative budget submissions; development and maintenance of financial management systems, payroll and accounting operations.

- o Administration of HCFA grant and contract activities to ensure compliance with relevant laws, regulations and other administrative requirements.

- o Provision of general administrative services, including management and control of records, mail, shuttle operations, real and personal property, security, safety, space planning, daily building operations, printing, distribution, teleconferencing, etc.

- o Administration of the personnel/position management activity.

- o Planning and coordination of management activities such as internal control, productivity improvement, paperwork burden reduction, workplanning, delegations of authority, organizational analyses and A-76 studies to determine the cost-effectiveness of contractor vs. government employee performance of work.

- Operation and management of administrative management computer systems; teleconferencing; and provision of centralized ADP/telecommunications support to program administrative functions Agency-wide.

- Performance of liaison and administrative support activities for the Regional Offices.

- Participation in a workgroup with the Inspector General's office to develop a model type of criteria edits for the detection of fraud.

- Management, development, and implementation of HCFA's Equal Opportunity Programs.

- Processing of Medicare-related correspondence and ADP exceptions generated by the Health Insurance System.

Major Highlights/Significant Accomplishments

Budget

- In FY 1987, three annual budget submissions (to OS, EOMB, and Congress) were prepared. In FY 1988, the combined budget for Medicare and Medicaid will exceed $128.7 billion under current law and cover more than 53 million people in the Medicare and Medicaid programs.

- HCFA received data from and provided data to 180 Medicare Intermediaries and Carriers, processed 150,000,000 queries, 62,000,000 bills and 268,000,000 physician payments; analyzed, corrected and re-entered 100,000 data rejects from Medicare ADP Systems; determined and reconciled payment liability on 285 HMOs and 54 Health Care Payment Plans totaling $2 billion.

- HCFA processed 130,000 responses involving duplicate Medicare cards, Part A utilization notices, Part B benefit explanations, Medicare Eligibility and Medicaid coverage inquiries.

- HCFA conducted annual reviews of States with a certified Medicaid Management Information System to determine whether the systems are operating according to Federal guidelines and develop and issue annual instructions to contractors to streamline operations and reduce administrative costs while maintaining program integrity. In addition, HCFA issued Claims Processing Assessment System performance instructions, prepare Systems Performance Review reports, developed and/or revised regulations, manual instructions and guidelines and made initial certification on State MMIS systems.

- Multiple annual apportionments were prepared for Grants to States for Medicaid ($27.6 billion); Payments to the Health Care Trust Funds ($20.8 billion); Program Management ($1.4 billion); and the Health Maintenance Organization Loan and Loan Guarantee Fund ($20.4 million). In addition joint apportionments were prepared for Federal Hospital Insurance and Supplemental Medical Insurance Trust Funds ($160.8 billion).

- Allotments and allowances for each initial apportionment or continuing resolution were prepared.

- Four status of funds reports and 26 biweekly employment reports were prepared. Individual ceiling allocations were issued for Bureaus and Offices; special analyses of staffing levels and requirements in selected areas were completed as needed.

- Administrative costs were allocated on an ongoing basis between the Medicare Trust Funds and General Treasury Revenues.

Accounting

- During FY 1987, approximately 1,750 daily and periodic financial reports were processed and reconciled.

- Approximately 340,000 financial transactions were processed.

- Approximately 22,300 check/Treasury Financial Communications System (TFCS) or cash payments, as well as 25,700 letter-of-credit payment vouchers were audited and processed.

Grants/Contracts/Procurements

- HCFA awarded 3,116 new contracts/modifications/ purchases valued at $204.7 million (including 784 PRO contracts/modifications valued at $167.6 million).

- HCFA administered 322 contracts valued at approximately $179 million.

- Procurement Preference Program, even scheduling and competitive goals were all met or exceeded, some to a substantial degree.

E4

- HCFA documented $6.16 million in savings through contract and grant negotiations.

- Awarded and administered 213 R&D grants/cooperative agreements/"waiver only" grants (new awards and continuations) valued at approximately $225 million.

- Award, modify, and administer "third round" PRO contracts approximating $625 million.

- Award, modify, and administer approximately 3,750 new contracts/purchases annually valued at about $70 million.

- Continue to achieve or exceed annual Procurement Preference Program, Even-Scheduling and Competitive Goals.

- Document savings realized annually through negotiation of contract and grant awards.

Administrative Services

- Addressed 2,500 security-related issues from a variety of requestors which include: HCFA employees; Federal Protective Service; Federal, State and local court officials; Office of Personnel Investigation, and other law enforcement agencies.

- In FY 1987, expanded the cardkey access system to add seven additional cardkey entrances. Cardkeys were distributed to all employees and contractors. In FY 1988, expand the cardkey system to include use with interior and perimeter system at all outlying buildings and selected areas of the East High and Low Rise Buildings.

- In FY 1987, HCFA added three guard posts to the contract. In FY 1988, will expand the existing guard service to provide additional onsite and mobile coverage to all outlying buildings and the East Complex.

- In FY 1987, implemented the wearing of ID badges in HCFA Baltimore buildings.

- HCFA investigated the use of electronic security devices to provide protection for the increase of personal computers, new telephones and other equipment being purchased.

- As of October 1987, HCFA received Delegation of Leasing Authority for all Baltimore-area leased buildings. HCFA now has responsibility for operation, maintenance, repair, preservation, alteration and protection of these buildings.

- In FY 1987, responded to 20,000 inquiries from Agency employees and the public (Receptionist).
- In FY 1987, maintained a computerized parking system for 2,700 Baltimore-based employees and Agency contractors. In FY 1988, total registration of all employees to take place.
- In FY 1987, responded to 3,500 facilities-related requests, which include building complaints, conference room requests, transportation services, issuance of IDs, etc.
- In FY 1987, identified and corrected 2,500 safety-related concerns from annual workplace safety inspections.
- In FY 1987, the National Institute for Occupational Safety and Health completed an environmental survey of the Meadows East Building as a result of work-related health complaints from employees. Their final report showed nothing harmful within the building, but made several recommendations to improve air quality. Implementation of the recommendations is in progress.
- In FY 1987, responded to 1,820 records reference requests.
- Monitored mail operations contract.
- Operated records temporary storage area.
- Conducted an annual records clean-up campaign.
- In FY 1987, responded to over 2,000 mail operations reference requests.
- Conducted four official mail samplings required by United States Postal Service.
- In FY 1987, accomplished relocation/rearrangements for approximately 300 HCFA employees in the Baltimore and Washington areas.
- In FY 1987, developed a new work space management plan for the regions which will accomplish the President's utilization goal of 135 square feet per employee by FY 1990. In FY 1988, plans will be further revised to reflect changes in staffing figures. Two regions have accomplished their space reduction. Four regions are

in the process of scheduling moves in FY 1988 while other regions are working with Regional Administrative Services Centers on developing move plans and schedules for FY 1989 and 1990.

- In FY 1987, moved 22 OIG employees from the Annex Building into the 1717 Equitable. The consolidation of the OIG staff will progress in FY 1988 based on the downsizing of DMOS staff.

- In FY 1987, redesigned space for Personnel staff on the ground floor, ELR. Installation of panels, carpet and drapes will be completed in FY 1988, pending availability of funds.

- Provided uninterrupted power source to the HCFA computer center in the Lyon Building.

- Constructed a shower/locker room facility through a HCFA contract with an SSA contractor. The shower/locker room facility supports the HCFA Fitness Center installed in FY 1986 for HCFA employees.

- In FY 1987, implemented a smoking policy, binding on all 2,200 HCFA Central Office employees, which bans smoking in Baltimore and Washington, D.C., HCFA-occupied space except in very limited designated smoking areas.

- In FY 1987, negotiated with Baltimore County, GSA and SSA officials for the installation of two new crosswalks, protected by pedestrian-activated walk lights, across Security Boulevard to enhance the safety of our Baltimore employees. The Federal Government and Baltimore County installed sidewalks for access to the crosswalk. In FY 1988, the actual crosswalks and walk lights will be installed.

- Implemented new distribution formula for HCFA provider manuals effecting 40 percent reduction in copies furnished free of charge to intermediaries.

- Provided labor/moving services responding to over 6,200 separate requests in FY 1987. Projected labor/moving services requests for Fy 1988 will be 7,000 and 7,500 for FY 1989.

- Developed a computer Graphics Network within HCFA, with Graphics as the focal point, using personal computers and special software.

- Merged automated forms, printing and distribution tracking system with warehouse inventory system to eliminate duplication, increase accuracy, reduce paperwork and provide shared access to all system data.

- Responded to approximately 700 requests for Graphic Services.
- Printed and distributed over 153 million Medicare forms to 300 customers nationwide via five forms ordering cycles at a cost of approximately $2.7 million.
- Processed 1,649 printing orders at an approximate cost of $4.8 million.
- Procured printing in support of the Hospital Mortality Rate project for the Administrator.
- HCFA personal property inventory equals $22 million in FY 1987. Projected Government property in possession of contractors and grantees in FY 1988 is $4 million and $5 million in FY 1989. HCFA personal property is projected to be 24 million in FY 1988 and $26 million in FY 1989.
- Provided data base research information and referral services to HCFA components. The Information Resource Center has current access to OLP's Legislative data base. HCFA will implement a gateway service to approximately 600 world-wide data bases, as well as SSA's and HCFA's cataloging data bases. New data bases are being canvassed.
- In FY 1987, developed the Printing and Property Stock Management System to control and manage the distribution, warehousing, inventory and ordering of materials requested by contractors, intermediaries and Government components.
- In FY 1988, HCFA will procure printing in support of the proposed catastrophic care program.
- HCFA will study the feasibility of contracting for a centralized copy center for HCFA.
- Contract for annual workplace survey to identify hazards.
- Implement efficient space configuration in HCFA warehouse.
- Transfer overnight delivery service (including budget) to central office components.
- Improve disposition of HCFA surplus property and acquire valuable property from other agencies.

- Develop an automated reprographics control system.

Personnel

- In FY 1987, processed 2,700 classification actions and two occupational studies affecting 100 positions. In FY 1988, we plan to process approximately 1,500 classification actions; 36 classification studies resulting in 400 actions and five occupational studies resulting in 300 actions. In FY 1989, we plan to process approximately 1,200 classification actions; 36 classification studies resulting in 400 actions and eight occupational studies affecting 500 actions.

- In FY 1987, processed 3,116 personnel actions and 13,726 payroll actions were processed. In FY 1988, we plan to process approximately 6,200 personnel actions and 12,000 payroll actions. In FY 1989, we plan to process approximately 6,200 personnel actions and approximately 12,000 payroll actions.

- In FY 1987, processed 3,000 Training and Authorization Forms and 1,044 awards. In FY 1988, we plan to process approximately 3,000 Training and Authorization Forms and 600 awards. In FY 1989, we plan to process approximately 3,000 Training and Authorization Forms and 800 awards.

- In FY 1987, processed 725 labor/management relations actions. In FY 1988, we plan to process approximately 750 labor/management relations actions. In FY 1989, we plan to process 800 labor/management relations actions.

Equal Opportunity

- Developed, revised, and reviewed 290 statistical and monitoring reports.

- Prepared Affirmative Action Plan Accomplishments and Update Reports and other related reports in accordance with EEOC requirements.

- Prepared and submitted the HCFA year-end EEO accomplishment report and adverse impact analysis.

- Reviewed and analyzed 100 merit pay actions (GM-13, 14, 15).

- Prepared and submitted four comprehensive Agency reports related to Secretary/Departmental EEO initiatives. (Hispanic Employment program, Handicapped Employment, and Disabled Veteran Employment, and Federal Women's Program).

- Developed and maintained supporting component coordination file for tracking EEO activity.
- Developed and implemented Affirmative Action Procedures for measuring Affirmative Action progress.
- Established and maintained an effective quarterly monitoring system.
- Conducted adverse impact analysis for 28 HCFA component offices.
- Prepared policy statement on sexual harassment.
- Coordinated EEO observances which included: Black History Month, Women's History Month, Asian/Pacific Heritage Week, Hispanic Heritage Week, American Indian Day, Women's Equality Day, Handicapped Week and Veterans Day.
- Represented HCFA at seven national conventions in an outreach effort to recruit minorities.
- Established EEO Committee to analyze EEO Program and advise Director, EOO.
- Processed conciliation and adjudication of approximately 150 informal and formal discrimination complaints.
- Developed and distributed comprehensive videotaped EEO training modules to train approximately 485 supervisors and managers.
- Developed a checklist to ensure greater control and timeliness of the complaint process.
- Developed a system to monitor the location of each case on a daily basis.
- EEO counselors participated in five training sessions.
- EEO coordinators (Central and Regional Offices) participated in a training program to implement the logistics for the video cassette EEO training for managers.
- Three training sessions were conducted on sexual harassment for HCFA managers.
- Establish and maintain an effective and efficient EEO statistical reporting system.

- Conduct visits to 28 component offices based on FY 1988-1992 Multi-year Affirmative Employment Plan.
- Develop an FY 1988-1992 Multi-year Affirmative Employment Plan required by EEOC.
- Work with the Office of Human Resources to establish the Federal Equal Opportunity Recruitment Program and monitor its progress.
- Establish a career advisory program for women in order to strengthen and expand the scope of the Federal Women's Program in HCFA.
- Conduct EEO training seminar for HCFA leadership, as well as EEO counselors and coordinators.
- Prepare an issue paper on Hispanic Employment.
- Coordinate four major training sessions sponsored by the Federal Women's Program focusing on career advancement.
- Develop and distribute three handbooks on EEO issues to HCFA managers and workforce.
- Develop a format to design a series of "How To's" for managers on the discrimination complaint process.
- Conduct internal audit of HCFA's EEO operation.
- Conduct three major EEO studies.
- Conduct sexual harassment training sessions for EEO counselors in Central Office.
- Conduct four EEO training sessions for Regional EEO counselors and coordinators.
- Participate in the tracking of the Early Complaints Resolution Process.
- Develop system to track and monitor discrimination complaints.
- Establish an effective quarterly tracking system to determine trends and patterns of discrimination.
- Develop an EEO Director's Bulletin for Central Office distribution.
- Develop an information dissemination program.

Management Analysis

- Maintain, evaluate, improve, and report on internal controls in HCFA program activities and administrative functions. Review and analyze the 16 internal control evaluations scheduled to be completed by HCFA components in FY 1988 and the 17 evaluations scheduled to be completed in FY 1989. Prepare and submit quarterly reports and an annual report on the status of internal controls in HCFA.

- Determine additional HCFA activities to include in a new inventory of potential A-76 activities. Provide assistance to components developing A-76 contracts and file periodic reports.

- Review proposals for advisory and assistance services contracts for compliance with OMB Circular A-120, departmental, and HCFA requirements. Review 65 proposals in FY 1988 and 70 proposals in FY 1989. Provide technical and analytical advice on the development of such proposals. Recommend certification where appropriate.

- Measure and track the FY 1987 Medicare Institutional Reimbursement Review Initiative Plan and the FY 1988 Medicare Claims Processing Initiative Plan during FYs 1988 and 1989. Develop, analyze, and submit FY 1989 plans for the Review of Federal Medicaid Payments to the States and the Peer Review Unit Cost initiatives in FY 1988. Measure and track the FY 1989 plans during FY 1989. Prepare and submit quarterly reports and annual report on the status of the Productivity Improvement Initiatives in HCFA's Productivity Improvement Program Inventory.

- Develop, analyze, measure and track Management Improvement Initiatives. Prepare and submit quarterly reports on the status of Management Improvement Initiatives.

- Revise the Memorandum of Understanding/Interagency Agreement review and approval process during FY 1988.

- Publish eight Privacy Act notices of new systems of records in the Federal Register in FY 1988 and ten in FY 1989. Amend five existing systems in FY 1988 and three in FY 1989. Coordinate 30 training sessions on Privacy in FY 1988 and 30 training sessions in FY 1989. Coordinate 300 complex Privacy Act requests/inquiries in FY 1988 and 300 in FY 1989. Update all 50 HCFA Privacy System records, and prepare two annual Privacy Reports to Congress each fiscal year.

- Process 20 Administrative Issuances System (AIS) issuances in FY 1988 and 20 in FY 1989 and complete an evaluation of the overall system.

- Transfer the Administrator's Management Plan (AMPs) to the mainframe computer in FY 1988. Focus AMPs on the Administrator's key goals and increase the intensity of analysis of AMPs projects.

- Completed the Biennial Review of 247 individual delegations of program authority. Also processed 50 new and/or amended delegations of authority. In FY 1988, plan to review, analyze, and process 60 new and/or amended delegations of program authority and in FY 1989, 320 delegations of program authority. The FY 1989 number includes the biennial updating.

- Reviewed, analyzed and revised 350 delegations of administrative authority. In Fy 1988, plan to review 300 administrative authorities and 350 in FY 1989.

- Completed 42 organizational reviews. In FY 1988 expect 60 and 65 in FY 1989.

- Completed seven special studies. In FY 1988, expect nine and in FY 1989 expect 11. Objective is to initiate more special studies on broad based issues and limited studies on specific organizational/ operational ad hoc issues based on management needs.

- Other objectives are to: establish information sharing and fact finding meetings with Bureau/Office Directors and subordinate organizations; develop organizational, position management profiles for these components and establish a comprehensive Agency-wide position management reporting system with a quarterly report to Bureau/Office Directors.

Operations Support

- Responded to 45,801 inquiries from States, OPM and private groups concerning the Medicare billing process for beneficiaries. Inquiries are anticipated to slow to 40,000 in FY 1988 and again to 30,000 in FY 1989.

- Analyzed and reviewed Medicare records and files to adjust 37,721 beneficiary utilization records. Adjustments are anticipated to drop to 28,300 in FY 1988 and stabilize at 28,300 for FY 1989.

- Responded to 235,512 inquiries from Federal agencies regarding enrollment of beneficiaries in the Medicare program. FY 1988 inquiries are anticipated to decline to 230,000 in FY 1988 and again in FY 1989 to 172,500.
- Responded to 730 congressional correspondence items; anticipating an increase to 750 items for FY 1988, 800 items for FY 1989.
- Responded to 193,000 general correspondence items for FY 1987; projecting increases to 196,000 items for FY 1988 and to 200,000 items for FY 1989.
- Processed 85,000 SOBER exceptions; projecting increases to 87,000 for FY 1988 and to 90,000 for FY 1989.
- Processed 28,000 miscellaneous exceptions; anticipate processing 30,000 in FY 1988 and 32,000 in FY 1989.
- Processed 15,176 NOUs for FY 1987. This workload has been discontinued.

Administrative Systems

- In FY 1987, developed and implemented new allotment, allowance and appropriation (AAA) system for use by the Division of Budget, OMB. System was developed to reduce cost of purchasing outside computer support and to provide management with a more accurate, cost efficient, responsive method of tracking, entering and querying budget requests and preparation of budget reports.
- In FY 1987, implemented Module I and II of the Correspondence Handling and Processing System.
- In FY 1987, developed an automated Time and Attendance System to be piloted by the Division of Accounting.
- In FY 1987, developed the Printing and Property Stock Management System to control and manage the distribution, warehousing, inventory, and ordering of materials requested by contractors, intermediaries and government components.
- In FY 1987, participated on evaluation team for PRISM competitions and began management of the administrative logical application group of PRISM.
- In FY 1987, began conversion of the Regulations Tracking System to run at the HCFA Data Center. This will be completed in FY 1988.

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- In FY 1987, provided numerous enhancement and modifications to over 40 separate administrative systems.

- In FY 1987, the Meadows East Electronic Meeting (MEEM) room was available for audio and video teleconferences on July 1. The first call hosted in the MEEM room occurred on August 11. Usage has been averaging 3-5 hours per week and is consistently rising.

- In FY 1987, managed a $3 million local source and nationwide FTS budget and serviced 3,700 telephone lines in the Baltimore/Washington area.

- In FY 1987, compared the Agency's current telephone system equipment and features with the new Northern Telecom, Inc. (NTI) equipment and available features. Recommendations from this indepth analysis included replacement of all HCFA's current equipment with NTI equipment. Basic feature packages were developed for easy conversion. Extensive, hands-on training sessions for employees were scheduled to ensure a smooth transition.

- A complete telephone conversion to NTI for voice communication was completed in April 1988.

- In FY 1988, HCFA will pursue the feasibility of upgrading facsimile equipment throughout the Agency to compatible, state-of-the-art models.

- In FY 1989, HCFA will attempt to reduce telecommunications costs through full implementation of the NTI switch.

- In FY 1988, redesign the Manpower Management System combining full-time equivalency ceiling control and manpower management reporting using a Data Base Management System. Upon completion of redesign, this system will then be moved from NIH to the HCFA Computer Center.

Field Operations Liaison

- Coordinate the activities of the Regional Office ADP Steering Committee to effectively utilize ADP resources to improve efficiency and productivity.

- Coordinate Operations-wide purchase of 200 microcomputers and software.

- Implemented the Operations Executive Office Automation System.

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- Conduct quarterly comprehensive management reviews analyzing Regional Office resources and accomplishments.

- Prepare special analyses and briefing documents on Operations utilization of resources related to Agency and Operations goals and objectives. Includes recommendations on shifting resources to meet priority objectives.

- Conduct quarterly Regional Administrators' conferences, weekly teleconference calls and prepare weekly status reports and special reports on specific programmatic topics.

- Prepare quarterly analyses of Regional Management System data and issue quarterly reports. Revise data collection methods incorporating a random sample method of data collection.

- Prepare quarterly reports and analyses of workload items of particular to senior management.

14. Executive Direction

This function is critical to the overall effectiveness and efficiency of the Agency in meeting its obligations to administer the Medicare and Medicaid programs and related provisions of the Social Security Act. These activities direct the planning, coordination and implementation of the operational programs and the development of effective relationships between these programs and other Federally supported health programs. In performing this function, executive staff:

- Promote the timely and economic delivery of quality health care to eligible beneficiaries.

- Promote beneficiary awareness of services and improve service accessibility.

- Promote efficiency and quality within the total health care delivery systems.

- Assure the financial integrity of the Medicare and Medicaid programs.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

HEALTH CARE FINANCING ADMINISTRATION

CATASTROPHIC HEALTH INSURANCE

Program Activity	FY 1988	FY 1989	FY 1990
Program Management	$47,900	$160,000	$305,000
FTEs 1/	50	125	125

As of the date of the Department submission, the passage of the Medicare Catastrophic Coverage Act of 1988 appears to be imminent. The amounts requested are the best current estimate. As the details of the enacted legislation become clearer, HCFA will refine and add specificity to the proposed budget expenditures for the implementation of the Catastrophic Health Insurance program. For the OMB submission HCFA should have a better perspective as to the specific activities required and associated costs.

The Catastrophic Health Insurance program will provide a comprehensive health benefit to cover all costs for beneficiary services after certain thresholds are met. With a planned phased-in implementation, catastrophic coverage will begin in 1989 with coverage of the defined Part A benefits. The inclusion of the Part B benefits is scheduled to begin on January 1, 1990. Coverage of prescription drugs begins with limited coverage in 1990 and increases in 1991 and the outyears.

The implementation activities of the Catastrophic Health Insurance program will affect most aspects of the Program Management account. The contractors will be required to make extensive systems changes in order to capture and share the data necessary for the successful implementation of catastrophic coverage. The Conference Committee Agreement requires numerous research studies which must be initiated. The administrative costs associated with the implementation activities include public information and awareness, training, FTEs, systems enhancements including hardware, software and telecommunications modifications.

1/ These FTEs are included in the count and the discussion of FTEs in the Administrative Costs section.

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HEALTH MAINTENANCE
ORGANIZATION LOAN AND LOAN
GUARANTEE FUND

FY 1990

HMO LOAN AND LOAN GUARANTEE FUND

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
PREPAID HEALTH CARE ORGANIZATION
LOAN AND LOAN GUARANTEE FUND

Authorizing Legislation: Title XIII, Public Health Service Act

(Dollars in Thousands)

Resource Requirements	FY 1988 Estimate	FY 1989 Estimate	FY 1990 Estimate
Budget Authority	$ 00	$ 5,000	$ 5,000
Program Output Data			
Number of Direct Loans	103	103	103
(Active)	(54)	(50)	(46)
(Defaulted)	(24)	(24)	(24)
(Repaid in Full)	(25)	(29)	(33)
Total Amount Disbursed	0	0	0
Cumulative Disbursements	$ 186,083	$ 186,083	$ 186,083
Principal Outstanding (held by HHS)	$ 3,213	$ 3,188	$ 3,150
Principal Outstanding (sold to FFB)	$ 86,009	$ 81,542	$ 76,687
Number of Guaranteed Loans	7	6	6
Number of Defaults	(2)	(2)	(2)
Total Amount Guaranteed	$ 13,536	$ 13,536	$ 13,536
Principal Outstanding (Loan Guaranteed)	$ 7,801	$ 7,251	$ 6,772

Rationale for the Budget Request

The Health Maintenance Organization (HMO) Loan and Loan Guarantee Fund was established as a revolving fund in 1975 with an initial appropriation of $35 million. The Fund served as a mechanism to provide working capital during the initial operating period of an HMO when financial deficits were expected. Direct loans were made to HMOs from the Fund and were sold, with a guarantee, to the Federal Financing Bank (FFB) to provide a continuous source of capital for making additional direct loans. The Fund also guaranteed the repayment of loans made by private lenders to HMOs.

The last direct loan commitments were made by the Loan Fund in FY 1983. No further commitments will be required or made.

The sole function of the HMO Loan Fund is to service the repayment of direct loans sold to FFB and loans guaranteed by private banks. Although manpower resources for monitoring the repayment of the loan is funded through the Administrative Costs budget, the Loan Fund serves as the mechanism for financing the repayments of defaulted loans.

Guaranteed private bank loans and loans sold to the FFB that are in default and are declared uncollectible are guaranteed by the Loan Fund or supplemental appropriations when the assets of the Loan Fund are (1) insufficient to either repurchase the loan from the FFB or private lenders, or (2) to make semiannual payments (of interest and principal, and annual payments of principal) on the defaulted loans. The assets of the loan fund also are used to finance deferred payments of principal and interest on loans for which the HMOs are potentially in default, but for which the long term viability of the HMOs may be saved by deferring payments.

In FY 1988, the Office of Prepaid Health Care is monitoring 46 active HMOs with direct loans, including those sold to FFB with a guarantee, and on 6 loans guaranteed by private lenders.

In May of 1987, HCFA transferred $14 million to FFB to pay loans which had been prepaid by HMOs. However, by prepaying the FFB, HCFA became obligated to the FFB for a premium of $2.5 million because the interest rate on the loans was substantially above the prevailing rate. While the prepayment action was fiscally prudent, we must now seek an appropriation of this premium, in addition to interest on this premium.

Because HCFA does not anticipate a supplemental appropriation or sale revenue in FY 1988 to defray these expenses, we are requesting a supplemental appropriation in FY 1989 of $5.0 million. Since the transfer of the HMO Loan Fund from HRSA to HCFA in FY 1987, unpaid prepayment premiums owed to the FFB have been accruing interest charges. At the end of FY 1988 HCFA will owe $4.0 million to the FFB. This includes an anticipated five additional prepayment premiums accrued in FY 1988. HCFA also anticipates four prepayments in FY 1989, which will impose an additional $1 million in prepayment premiums. An additional $ 5 million will be required for FY 1990.

HCFA is also planning to sell the HMO Loan and Loan Guarantee Fund portfolio as part of a $20 plus billion government wide asset sale program pending resolution of issues related to the prepayment premiums, interest charges, and revenue shortfalls. HCFA is not requesting funds to support the asset sale proposal at this time because it expects administration proposals addressing this issue to be passed by law. If however, that does not happen, HCFA may need additional funds as the asset program progresses.